STATE TITLE V BLOCK GRANT NARRATIVE
STATE: OH
APPLICATION YEAR: 2006

I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. ASSURANCES AND CERTIFICATIONS

The assurance and certifications for Ohio can be made available by contacting

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D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

The Ohio Department of Health made the Maternal and Child Health Block Grant application, including the Needs Assessment, available for public input by placing it on the ODH webpage. Notification of such was sent to the Maternal and Child Health Advisory Committee and MCH Needs Assessment stakeholders. Stakeholders represented DFCHS grantees, other state agencies, local organizations, provider and professional groups and to some extent, parents/consumers.

The current application will be available on the ODH website at
http://www2.odh.ohio.gov/Resources/repts1.htm

We received comments from three interested parties: 1) Prevent Blindness Ohio; 2) the ODH Division of Prevention, Healthy Ohioans Initiative; and 3) March of Dimes, Ohio Chapter.

II. NEEDS ASSESSMENT

In application year 2006, the Needs Assessment must be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

III. State Overview
A. Overview

The Health of Ohio
In comparison with other states, Ohioans' health status is about average. Ohio does very well on some measures: mortality from motor vehicle injuries; HIV, and insurance rates. However, Ohio does poorly on measures of birth outcomes such as infant mortality and low birth weight; on measures of health behaviors such as smoking, obesity, diet and physical activity; and on rates of mortality associated with those behaviors: heart disease, stroke and cancer. Disparities, particularly those among blacks and in Appalachia, contribute heavily to poor indicators that diminish Ohio's overall health status.

Demographics
Ohio ranks seventh in the nation in population, with an estimated 11,435,789 people, including 3.5 million children under the age of 22. In the year 2003, there were approximately 2.4 million women in Ohio who were of childbearing age (15 to 44 years). In recent years, Ohio has averaged about 150,000 live births annually. The birth rate has been relatively stable for the last five years.

According to the 2002 National Survey of Children with Special Health Care Needs (CSHCN), the total number of CSHCN in Ohio is 402,800 children or 13.9 percent of children under 18 years of age. The survey identified 338,550 Ohio households with CSHCN or 22 percent of the state's households. In comparison, the survey identified 9.4 million CSHCN nationally or 12.8 percent of children under 18 years of age. Nationally, 20 percent of all households had a CSHCN.

Ohio has a land area of 40,953 square miles and is divided into 88 counties. An estimated 81 percent of the population in Ohio resides in metropolitan areas. The ten counties with the largest populations are Cuyahoga (includes Cleveland), Franklin (Columbus), Hamilton (Cincinnati), Montgomery (Dayton), Summit (Akron), Lucas Toledo), Stark (Canton), Butler (Middletown), Lorain (Lorain), and Mahoning (Youngstown). The Ohio Family Health Survey categorized the 88 counties as metropolitan (12), suburban (17), rural non-Appalachian (30) and Appalachian (29).

Ohio has no geographic barriers. However, while Ohio has a highway system that connects most parts of the state very efficiently, the southeast region of the state, including most of Ohio's Appalachian counties, lacks a good highway system, creating a lack of accessibility to both jobs and health care. Pockets of inner city poor and the 19 percent of the population living in rural areas lack access to primary health care services. Access to specialists often requires travel to urban areas of the state. Ohio has seventy-six federally designated health professional shortage areas distributed within 51 of its 88 counties. The greatest areas of unmet need are in metropolitan and Appalachian counties. The designated primary care HPSAs in Ohio are more prevalent in urban areas than rural areas; 71 percent are located in urban areas and 29 percent are in rural areas.

Since 1990, Ohio has had an increase in ethnic and racial minorities as a percentage of the population. The Hispanic population, composed mainly of persons of Mexican and Puerto Rican origins, accounted for 15 percent of Ohio's net growth since 1990. Likewise, the black population accounted for 29 percent of Ohio's net growth since 1990. The three largest groups of Asian populations in Ohio are of Indian, Chinese and Korean origin. In 2003, 85.4 percent of the population was white, 11.7 percent was black, 1.4 percent was Asian or Pacific Islander, and 0.2 percent was Native American and Alaskan Native. These groups may also include Hispanics, who make up two percent of the population. In 2000, 2.2 percent of Ohio's population was composed of persons identifying themselves as being of two or more races.

Health Priorities for Ohio
Of the five priorities established by Governor Bob Taft for his administration, three are directly related

to improving and protecting the health of Ohioans: Enabling every child to succeed; caring for those not able to care for themselves; and promoting public health and safety.

The Ohio Department of Health (ODH) is the agency charged with protecting and improving the health of all Ohioans. In order to carry out this mission, ODH has adopted a strategic plan based on the concept of Healthy Ohioans in Healthy Communities. Title V and other programs in the department are guided by the following core values in this plan: leadership, excellence, accountability, partnership and citizenship. Leadership within the Ohio Department of Health produced a set of priorities for 2005 that remained the same as for 2004. The Director's Performance Goals 2005 (with a listing of MCH-related objectives) are as follows (see entire list in the attachment in Section IV: Priorities, Performance and Program Activities.).

* Encourage healthy choices
- Establish baseline number of overweight Ohio children
* Prevent chronic, environmental, genetic, and infectious diseases
- Increase immunization rates of two year olds
* Eliminate health disparities
- Improve access to dental care for vulnerable Ohioans through dental workforce
- Increase coordination of programs for families and children under age 6
- Develop and implement a Birth Defects pilot program in two areas of the state
- Expand participation of local health departments in Medicaid Administrative Claiming (MAC)
- Establish a baseline number of minority physicians needed to match racial and ethnic composition of Ohio's urban health professional shortage areas
- Increase the number of medical homes for CSHCN
* Assure public health preparedness and security
* Assure quality and safety of health care services
* Improve business performance

Process to Establish Title V Needs and Priorities:
During 2004 and 2005, in anticipation of the FY2006 MCH Block Grant application, Ohio conducted a comprehensive assessment of the health needs of women and children in the state. The assessment consisted of various components including a review of the data on a wide variety of health issues, a review of Ohio and national demographic data, consumer input through focus groups, key stakeholder opinions, and professional judgment from those working in the field. Input was specifically solicited from DFCHS-funded local agencies, WIC projects, and local health districts. The needs assessment process and resulting priorities are more fully described in other sections and have been used to guide Ohio's MCH Block Grant-funded activities and grant applications for 2005-2006. Ohio utilizes the Community Health Improvement Cycle model that can be found in the attachments.

The MCH Advisory Council assists DFCHS by advising on block grant funded programs and the population served by the Title V Program. Representatives from the Council served on each of the Needs Assessment stakeholder groups. The Council is composed of maternal and child health professionals in both the public and private sectors, clinicians, administrators, policy makers, MCH advocates, consumers, state agency representatives, academicians and state legislators. They are appointed by the Director of Health and meet at least once a year.

The most important health care needs and issues identified by the comprehensive assessment of the state's maternal and child health population can be considered by population group:

Women's Health, Birth Outcomes and Newborn Health
* Access to Adequate Prenatal Care/Health Insurance
* Preterm Births/LBW
* Preconception/Family Planning/Unintended Pregnancy/Genetics Referrals and Services
* Neonatal/Perinatal Mortality
* STDs/HIV/Hepatitis

* Overweight/Nutrition
* Smoking
* Interconceptional Care
* Mental Health/Postpartum and Perinatal Depression

Early Childhood
* Health Coverage and Access to Care
* Access to Comprehensive Services including: Immunizations, Oral Health, Vision, Hearing, Lead Screening, Behavioral and Mental Screening
* Infant Mortality
* Child Care and Development
* Child Injury
* Child Death
* Overweight
* Social/emotional Health Issues
* Environmental Issues

School Age and Adolescents
* Insurance/Health Care Access and Use
* Chronic Disease Prevention
* Screenings (includes Oral Health, Vision, Hearing , BMI
* Mental Health Issues
* Sexual Behaviors
* Substance Abuse Issues
* Suicide
* Motor Vehicle Issues

Children with Special Health Care Needs
* Insurance/Access/Payment Issues
* Care Coordination: Medical Home/Community
* Services for Congenital and Genetic Conditions
Transition
* Access to Specialty and Specific Health Care Services
* Mental Health
* Medical Condition and Services
* Impact on Family

The considerable overlap of issues among these population groups was taken into consideration by the DFCHS chiefs in their deliberations in making recommendations on the top ten priorities for the MCH Block Grant.

The top ten priorities (in no priority order) are listed below:
* Improve birth outcomes
* Assure quality screening, identification, intervention, care coordination and medical home
* Assure access to comprehensive preventive and treatment services for individuals and families, including Children with Special Health Care Needs
* Promote age-appropriate nutrition and physical activity
* Improve oral health and access to dental care
* Enhance social/emotional strengths of families
* Increase collaboration and coordination of programs for families through partnerships and data integration
* Incorporate racial/ethnic/cultural health equity in all activities
* Decrease substance abuse and addiction, including tobacco
* Promote sexual responsibility and reproductive health
Ohio Health Care Systems to Deal with Identified Need

Health Care Delivery Environment: Medicaid
The Medicaid program is the most significant source of payment for health care services for low-income Ohioans. The Ohio Department of Job and Family Services (ODJFS) is the single state agency in Ohio with responsibility for administering the health care needs of Medicaid eligible persons including the health care needs of childbearing women, infants, and children. As in other parts of the country, Ohio's Medicaid program is undergoing major changes as Medicaid spending outpaces the growth of state revenues.

In SFY 2004, Ohio Medicaid provided comprehensive health care coverage to:
* 1 million children, including 45 percent of children under age 5;
* 265,000 non-elderly adults and children with disabilities;
* Over 490,000 low income parents;

The Ohio Medicaid program offers two delivery systems: the Fee-For-Service (FFS) and Managed Health Care System via the Managed Care Plans (MCP). The FFS system is a traditional indemnity health care delivery system in which payment is made to a health care provider after a service is delivered. Medicaid MCPs operate in 15 Ohio counties for the Healthy Start and Healthy Families population.

One of Medicaid's program categories is the Covered Families and Children (CFC) category of Healthy Start/Healthy Families that provide health care coverage for pregnant women and children who are not eligible for other Medicaid programs but meet the income guidelines for Healthy Families. Healthy Families allows up to 12 months of coverage for families who would lose coverage because of an increase in income (Transitional Medicaid) It can provide assistance to pregnant women at any age, and infants, children and teens up to age 18.

Pregnant women: Provides time-limited health care coverage to low-income pregnant women with family incomes at or below 150 percent of poverty. Coverage begins following confirmation of pregnancy and ends two months following birth. Ohio has not elected to exercise the option of presumptive eligibility for pregnant women. However, Ohio does have Expedited Medicaid -- the criteria being proof of pregnancy with expected due date signed by a doctor or nurse and statement of income. A face-to-face interview is not required. In SFY03, 30.1 percent (42,759) of the Ohio's total births were covered by Medicaid.

Infants and Children: Healthy Start provides health care coverage for children from birth through age 18 in families with incomes up to 200 percent FPL. Children in families with incomes at or below 150 percent PFL are eligible regardless of other health coverage. Children in families with incomes at 151-200 percent FPL are eligible only if they do not have creditable health coverage. Newborns are deemed eligible for 12 months if the mother was eligible for Medicaid at the time of birth, regardless of subsequent changes in the mother's income.

Ohio's State Health Insurance Plan for Children (SCHIP): As part of the Medicaid expansion of the Healthy Start program, Medicaid eligibility was increased for children up to 150 percent of FPL on January 1, 1998. In July 2000, Ohio further expanded Healthy Start under SCHIP. This expansion raised the income limit for eligibility up to 200 percent FPL. For this second SCHIP expansion, there was no complementary Medicaid expansion for the under-insured children, so children in this income range (151-200 percent FPL) are only eligible if they are uninsured.

Healthy Families previously known as Low Income Families provides health care coverage to families (parents and children). The majority of families receiving Healthy Families coverage are working families. A smaller group receives Ohio Works First (OWF) cash assistance. On July 1, 2000, Healthy Families coverage was expanded to families earning up to 100 percent of the Federal Poverty Level (FPL).

Medicaid Managed Care
Medicaid Managed Care operates in 15 counties. There are three (3) categories of Managed Care

counties: four counties are mandatory for Healthy Start eligibles; six counties are preferred options which means that Healthy Start eligibles are automatically enrolled in a managed care plan unless they choose to be in the FFS program; and five counties are voluntary counties which means that a Healthy Start eligible may choose to be in a MCP or in the FFS program. Those eligible through the aged, blind, and disabled categories remained on the FFS program.

In March 2005, Medicaid managed care enrollment was 525,699 as compared to an enrollment of 252,902 in September 1999. Historically, 1997 through 2000 was a time when cash assistance and Medicaid eligibility were delinked as a result of welfare reform. As a result many lost their eligibility for cash assistance and were disconnected from Medicaid coverage. Between July 1997 and September 1999, the number of families eligible for Medicaid/Healthy Start dropped from 651,651 to 546,405, a decrease of 16 percent. This now compares to a total statewide Medicaid eligibles (MCP and FFS) of 895,215 with 45 percent HF/HS eligibles enrolled in MCPs.

Medicaid Administrative Claiming
ODH has been working with ODJFS and more recently with the Centers for Medicare and Medicaid Services (CMS) to implement the Medicaid Administrative Claiming (MAC) program. Activities reimbursed as Medicaid administrative costs are not subject to the same rules and regulations that drive the delivery and reimbursement of Medicaid services. MAC in federal regulation is defined as activities that are "necessary for efficient administration of the State Plan" Historically, federal reimbursement has been provided for activities that increase access to Medicaid and that assist in improving the quality, appropriate usage, and effectiveness of services. These activities include outreach; referral, coordination and monitoring of Medicaid Services; and program planning, development and interagency coordination of medical services. Thus, Medicaid administrative claiming opportunities are logically focused in communities and among populations with the greatest disparity in health outcomes. MAC will allow ODH and its local partners to reinvest its reimbursements in community-based health-related programs.

Health Care Delivery Environment: Title V
Ohio's Title V Program provides the linkage among the many constructs that impact programs for the maternal and child population. Required MCH core performance measures are evaluated against the results of the state's needs assessment priority areas; State Child Health Insurance Program and other welfare reform programs are directly related to the health care services provided by the Title V Program. Initiatives such as Ohio Family and Children First and the Ohio Department of Health's Strategic Planning Priorities also must inter-relate with the activities funded through the MCH Block Grant.

Ohio's Title V Program is able to work within these programs and initiatives and has become more efficient and responsive to the needs of the MCH population. For example, within the Child and Family Health Services program, local programs that receive Title V funds are familiar with MCH Block Grant performance measures and prepare their grant applications to ODH by population group and level of the MCH service pyramid, based upon their own county-level needs assessment. Title V dollars expended on direct service at the local level are used to augment the publicly-funded safety net. Medicaid and other third party payers are billed by local clinics, while Title V funds are used for those persons who have no other means of paying for services.

With the exception of vision and hearing screening, all primary and preventive care services in Ohio's Title V program are provided by grantees of the Ohio Department of Health's Division of Family and Community Health Services. These grantees are often local health departments, but they may also be hospitals, community action agencies, and other non-profit community agencies.

Overview of the Child and Family Health Services Program (CFHS)
CFHS is not only a network of clinical service providers, but also local consortiums of health and social services agencies that identify the health needs, service gaps, and barriers to care for families and children and then plan clinical and community public health services to meet those needs. It also assures clinical child and adolescent health, prenatal, and family planning services for some low

income families and children (e.g., legal immigrant children, ineligible for Medicaid by federal mandate even if otherwise meeting family income guidelines), Funding of 79 local sub-grantees is done with a with a combination of Title V and state dollars. CFHS consortiums are also linked to the county Family and Children First Councils, Medicaid, and the Help Me Grow program. The program is more thoroughly described in Section B.

CFHS Projects are necessary even though Medicaid provides substantial funding of health care for the MCH population, including children with special health care needs. For those children residing in Medicaid mandatory managed care counties, the CFHS clinics would be one of the choices that the family would have for a child health care provider. In many rural counties however, the CFHS clinic may be the only provider in the community who will accept Medicaid eligible clients, and those with no ability to pay for services.

Overview of Children with Special Health Care Needs (CSHCN)
The Title 5 CSHCN Program is facing the challenge of decreased funding and increasing need by increasing coordination with Medicaid and private insurance payers, reducing the scope of clinical services, and reducing the number of children whose families remain financially eligible. In the past year the program has increased its commitment to service coordination by supporting team service coordination for children with hemophilia and other clotting disorders. The program is supporting the Medical Home for all children and especially CSHCN. The CSHCN program continues to network closely with the Medicaid and Early Intervention programs. The Title 5 program for CSHCN is developing a new electronic medical record system which will aid greatly in the matching of CSHCN with the services they need.

Overview of Help Me Grow
Help Me Grow is an innovative statewide program for mothers-to-be and their young children. The program was started in 1995 by the Ohio Family and Children First Initiative within the Governor's office in consultation with the state's healthcare, public health, social service and business communities. It is a comprehensive system of services administered through local councils for Ohio families. These services include information about pregnancy, voluntary home visits by to newborns and their parents by a registered nurse to families with infants and toddlers who are extremely vulnerable because of environment, family, or health circumstances and services and supports and services for children who have developmental disabilities (Part C of IDEA). The system is described in more detail in Section B.

Regional Perinatal Center Program (RPC)
Since 1977, Ohio has been divided into six perinatal regions based on the adoption of the State Perinatal Guidelines in response to the national recommendations for the Regional Development of Maternal and Perinatal Health Services (Toward Improving the Outcome of Pregnancy I). These regional designations were based on established referral patterns among hospitals and professionals capable of providing varying levels of maternity and newborn care. ODH further determined that at least one entity would be available within each region to serve as a hub for the Regional Perinatal Center Program. This population based Regional Perinatal Center Program is designed to promote access to evidence-based and risk-appropriate perinatal care to women and their infants through regional activities with the goal of reducing perinatal mortality and morbidity. The system is described in more detail in Section B.

Health Care Delivery Environment: Federally Qualified Health Centers (FQHCs)
Federally Qualified Health Centers also play a vital role in the delivery of primary and preventive care to pregnant women, mothers, infants, children, adolescents, and CSHCN. Financial resources are distributed to provide improved access to health care for the Maternal and Child population. From October 1, 2003 through September 30, 2004, Health Priority Trust (tobacco settlement) and funds and state funds were distributed to pay for health services for uninsured women, pregnant women and children. A total of 88,897 unduplicated patients (pregnant women, children less than 1 year old and children 1-18 years old) received care in Federally Qualified Health Centers or in the free clinics throughout the state.

Ohio has 76 federally designated health professional shortage areas distributed within 51 of its 88 counties. An additional 153 physicians are needed to serve the 1.6 million Ohioans residing in these shortage areas. The Division of Family and Community Health Services has six programs to recruit physicians, both primary care and sub-specialty trained, to work in underserved areas. These programs include a federal scholarship program, two federal, and one state loan repayment program (for American physicians) and the J1 Visa and National Interest Waiver programs for the placement of foreign born physicians. In 2004 Ohio placed 4 pediatricians, 1 OB/GYN, 1 Nurse Practitioner, 4 psychiatrists, and 1 social worker through these programs.

The Primary Care and Rural Health section in the Division of Family and Community Health Services provides CFHS program coordinators information about physicians who are placed in health professional shortage and medically underserved areas (HPSAs, MUAs) of the state via six different physician placement programs. All of these physicians are Medicaid providers and most accept uninsured clients using a sliding fee scale based on 200 percent FPL.

The Primary Care Section in the Division compiled the Statewide Assessment of Unmet Need (SAUN) to identify areas of the state with the greatest health care needs, disparities and workforce shortages. The analysis looks at health status indicators, the existence and utilization of primary care resources, and over-utilization of non-primary care resources recognized for their relationship to health care access. Resulting county profiles (modeled on the FQHC Need for Assistance criteria) serve as a useful resource tool for communities seeking FQHC and other funding and are posted on the ODH web site.

Health Care Delivery Environment: Local Health Departments
There are 136 local health departments in Ohio. Sixty-one of Ohio's 88 counties have one health department. The other 27 counties contain 75 departments, an average of nearly three per county. Ohio is a "home rule" state; the state health department does not have authority over local health departments except through some statutory requirements for environmental health and subsidy.

In 2005 ODH implemented Local Health Department Improvement standards which are available at http://www.odh.ohio.gov/LHD/PSWstan.pdf which do not represent an increase in the number of standards pertaining to subsidy, but they do represent a change toward a continuous quality improvement approach taking into consideration Ohio's first Public Health Standards, the current ODH goals, the Core Public Health Functions, and the National Public Health Performance Standards based on the ten Essential Services.

A Performance Standards Workgroup (PSW) developed Goals, Standards and Measures. There are 6 goals and 25 standards and a compendium of optional public health measures associated with the standards.
The goals are:
1) Protect People from Disease and Injury (includes 5 standards)
2) Monitor Health Status (includes 3 standards)
3) Assure a Safe and Healthy Environment (includes 5 standards)
4) Promote Healthy Lifestyles (includes 3 standards)
5) Address the Need for Personal Health Services (includes 4 standards)
6) Administer the Health District (includes 5 standards)

In order to receive the yearly subsidy payment, each local health departments submits an application reporting on how it meets the Improvement Goals and Standards. The intended goal is a continuous quality improvement approach.

All ODH grants programs must state which of the Local Health District Improvement Goals will be addressed; all applicant agencies that are not local health districts must communicate with local health districts regarding the impact of the proposed grant activities on the Local Health Districts Improvement Standards.

Other Issues that Impact Health in Ohio

The ODH strategic priorities, described earlier, have been set for each of the last several years based on annual assessments of needs, wants, and resources. With significant reductions in state public health funding combined with potential or proposed cuts in federal funding, this process is producing significant shifts in current and planned funding for maternal and child health. The department decided against across-the-board cuts at the time of earlier reductions, with priority to activities designed to stop disease spread. Over the past five years Title V and other federally funded initiatives have supported efforts to transform funded projects from direct care to other efforts designed to strengthen community resources for treatment, including local needs assessments, linkages with safety net providers, and targeting of health care provider placement programs. The Legislature has proposed a study commission to address the need for a comprehensive long-term funding solution to support treatment services for children with special health care needs.

Economic Issues that Impact Health In Ohio

Ohio Commission to Reform Medicaid

Ohio's budget bill (House Bill 95) called for the creation of the Ohio Commission to Reform Medicaid to evaluate the Medicaid program and make recommendations to Governor Bob Taft, the Speaker of the House, and the Senate President about reform and cost containment initiatives by January, 2005.

The Commission recently completed its tasks and provided recommendations with action steps to reform Medicaid. The commission recommended that Ohio's current Medicaid eligibility standards for low-income families and children, who represent 74 percent of the covered lives, but only 24 percent of costs, should be maintained.

Budget Cuts to CSHCN

The Ohio CSHCN Program (BCMH) had funding partially restored in the State GRF Budget for SFY O6/07. This will enable the BCMH Treatment Program to restore the Financial Eligibility Criteria to its previous level. This has the potential of restoring financial eligibility for many middle income families ($35,000 to $55,000). Many of these families have health insurance, but BCMH assists with payment for co-pays, medications, and treatments not covered by their insurance plans. While the BCMH Treatment Program is able to increase eligibility for this population the legislature removed the religious exemption for application to the Medicaid Program. This will largely affect Ohio's large Amish population. BCMH is working closely with the Amish Community and the Children's Hospitals to find ways to address this need.

Other Concerns:

Prenatal care providers, particularly obstetricians, have expressed concerns about rising malpractice rates, and we have heard occasional reports from local grant recipients about difficulties in finding providers. Legislation is pending that would cap damages; another proposal would extend liability protection to those providing free care.

In Ohio, 81 percent of the population lives in metropolitan areas. Pockets of inner city poor and the 19% of the population living in rural areas lack access to primary health care services. Access to specialists is often non-existent. Ohio's MCH Block Grant application is focused on assuring that services are available and accessible to women and children. As part of a department-wide strategic plan, the MCH Block Grant will be joining efforts to reduce health disparities and promote access to primary health care services. Activities to assist eligible women and children in the enrollment of expanded Medicaid programs will be supported. Providers will be recruited to become Medicaid providers, especially dentists. Primary prevention activities will be conducted. And, outreach workers will be provided to work within high-risk neighborhoods to identify and assist pregnant women and mothers. There is a concerted effort to integrate priorities identified through the needs assessment with priorities determined by the state agency and collaborative intervention efforts.

B. AGENCY CAPACITY

B. Agency Capacity
The State of Ohio has the capacity to provide comprehensive quality care to pregnant women, mothers and infants, children and adolescents, and children with special health care needs (CSHCN) through services administered in the Ohio Department of Health (ODH). ODH is the designated state agency for implementation of the Title V Maternal and Child Health Block Grant (MCH BG) and has established the Division of Family and Community Health Services (DFCHS) for this purpose and for the purpose of ensuring the provision of maternal and child health programs at the state and local level. DFCHS is also responsible for implementation of the following state statutes that impact the Title V program:

1) Birth Defects Information System: authorizes identification of children with birth defects; ensure they are linked with medical and support services; educate Ohioans on prevention; 2) Child Fatality Review (CFR): establishes a child fatality review board in each county; establishes rules and procedures for CFR: maintaining a comprehensive database, materials, and training to members of CFR boards; prepare and publish annually a report organizing and setting forth the data; recommend any changes to law and policy that might prevent future deaths; 3) Lead Poisoning: requires that each child at risk of lead poisoning undergo a blood lead test in accordance with guidelines established by the Centers for Disease Control and Prevention. In the event that a child is identified with lead poisoning, the source of the lead must be identified and abated; 4) Save Our Sight Program: created public donation supported children's vision conservation program to ensure that children in Ohio have good vision and healthy eyes; 5) Sudden Infant Death Program: requires the reporting of sudden unexpected deaths of children under the age of two, and the provision of counseling or supportive services; 6) Universal Newborn Hearing Screening: requires that every newborn receive a physiologic hearing screening prior to hospital discharge; 7) Vision and Hearing Screening: requires ODH to establish methods and procedures for school hearing and vision screening, and allows for screening data collection; 8) Women's Health Services Program: established the Women's Health Services Program.

PROGRAM CAPACITY
The following is a description of preventive and primary health care services for reproductive age women and men, pregnant women, mothers, infants, children and adolescents, and CSHCN provided through Ohio's Title V agency. Since bureaus within DFCHS are responsible for administering most of these MCH-related programs, close coordination with non-MCH BG programs occurs. DFCHS has approximately 60 different funding sources supporting its many public health service programs.

Child and Family Health Services Program (CFHS): ODH Title V administers a number of programs to improve the health status of reproductive age and pregnant women, infants, children and CSHCN including direct care, enabling, population-based, and infrastructure services. CFHS is a community based program that uses a combination of federal, state and local monies to provide public health programs and services, including safety net clinical services to low-income un/underinsured families and children in Ohio. The program is designed to eliminate health disparities, improve birth outcomes, and improve the health status of women, infants, and children. Currently 79 agencies in 80 counties (e.g., local health departments, hospitals, community action agencies and other nonprofit agencies) hold CFHS grants. There are five components in the CFHS Program: 1) Community Health Assessment (required); 2) Child Health; 3) Family Planning; 4) Prenatal Health; and 5) OIMRI. The maximum funding a county can apply for is determined by a formula similar to the one used to

allocate funds for the MCH BG. The Ohio MCH BG process will be used to narrow the focus of the CFHS areas of investment. Applicant agencies are limited to strategies that address the MCH BG priority topics. Applicant agencies must develop strategies based on best practices research with clear, measurable benchmarks for each strategy. CFHS projects have been asked to re-evaluate their need to provide direct care services. DFCHS collaborated with the OSU School of Public Health and the National Association of City and County Health Officials to provide regional strategic decision making process workshops for CFHS projects.

Preconceptional and Interconceptional Health Services
Family Planning: Ohio Title V has two programs that address the improvement of preconceptional and interconceptional health at the direct service, enabling and population levels. The first is Family Planning. The ODH Family Planning Program uses a combination of federal (Title X and Title V), state and local monies to offer women's health services including contraceptive and gynecologic health care; breast and cervical cancer screening; Sexually Transmitted Diseases (STDs), including HIV/AIDS information, screening and treatment; and other health screenings (e.g., hypertension, smoking, health risk behaviors). The family planning projects also provide community education and infertility information. The goal of the family planning program is to improve the health and well-being of women, infants, children and families by assuring health care access for a vulnerable population of low-income women. Programs are focused on the target population of clients who are at the greatest risk for poor health outcomes.

Women's Health Services Program (WHS):The second program that addresses preconceptional and interconceptional health is the WHS Program, established by state law in 2003, and funded with dollars formerly utilized by family planning delegate agencies that received federal Title X family planning funds. Services for this program are limited to: pelvic exams and lab testing; breast exams and patient education on breast cancer; screening for cervical cancer; screening and treatment for STDs and HIV screening; voluntary choice of contraception, including abstinence and natural family planning; patient education and pre-pregnancy counseling on the dangers of smoking, alcohol, and drug use during pregnancy; education on sexual coercion and violence in relationships; and prenatal care or referral for prenatal care. Priority for these services are clients who have incomes at or below 100% of the federal poverty level and who are either uninsured or underinsured. Consideration for funding was given to provision of services in underserved areas or expansion of existing programs to achieve a balance of services and address health disparities. Twenty local health departments were funded in CY2004 to provide services with these funds; nine programs were funded to local health departments that had not previously provided this range of services. Three of the funded agencies new to these services are located in urban areas and are serving a disparate population of low-income, African-American clients. Other programs used to improve preconceptional health are described in the CSHCN section on genetics.

Services to Promote Improved Pregnancy Outcomes
Child and Family Health Services Program (CFHS): The prenatal health component of the CFHS program (described above) provides direct, enabling, population, and infrastructure services to low income un/underinsured pregnant women.

Ohio Infant Mortality Reduction Initiative Program (OIMRI): OIMRI is an enabling service that will be incorporated into the CFHS program for FY2006. Currently the program funds twelve OIMRI projects that target those census tracts or neighborhoods with high-risk, low-income pregnant women for first trimester prenatal care. The OIMRI Program utilizes the community care coordination model to empower communities to eliminate disparities. The community care coordination model supports employing individuals from the community as trained advocates (Community Care Coordinators {CCC}) who empower individuals to access resources. The services focus on achieving success in health, education, and self-sufficiency. The CCC makes home visits on a regular basis during pregnancy and through the baby's second year of life; identifies and reinforces risk reduction behaviors; and collaborates with other agencies in making appropriate referrals when necessary to assure positive pregnancy and infant health outcomes. While Ohio has a safety net system of health care for un/underinsured and Medicaid consumers, significant barriers to pregnant women and

children accessing those services remain. The OIMRI Program addresses the barriers (e.g., financial, geographic, cultural) that women and children experience and improves their access to and utilization of health care.

Prenatal Smoking Cessation Services Program (PSCP): PSCP was created in response to the startling rates of smoking among pregnant women in Ohio and is a partnership with the March of Dimes; American Cancer Society; the Smoke-Free Families National Dissemination Office; and the American College of Obstetricians and Gynecologists. As an infrastructure service, PSCP has provided training to more than 500 prenatal care providers on an evidence-based intervention, the "5 As" (Ask, Advise, Assess, Assist and Arrange). PSCP thus is focusing its efforts to design and build client and provider systems necessary to support both prenatal care providers and pregnant and postpartum women to make changes which are critical to reducing smoking rates. WIC and Help Me Grow will provide PSCP access to their existing systems, services and materials for prenatal and postpartum tobacco treatment.

Regional Perinatal Services Program (RPC): Since 1977, Ohio has been divided into six perinatal regions based on the adoption of the State Perinatal Guidelines in response to the national recommendations outlined in Toward Improving the Outcome of Pregnancy I. ODH determined that at least one entity would be available within each region to serve as a hub for the RPC Program. This population based RPC Program is designed to promote access to evidence-based and risk-appropriate perinatal care to women and their infants through regional activities with the goal of reducing perinatal mortality and morbidity. Since 2002 the program has been in the process of moving from outreach education toward data driven performance monitoring and quality improvement. The program is using the perinatal Data Use Consortium approach (based on CityMatCH and CDC) to engage health professionals from medicine and public health into a regional team to advance data-driven projects and activities. All maternity and newborn care hospitals, local health departments and other public health entities are assisted by the RPC program.

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC): The DFCHS Bureau of Nutrition Services (BNS) administers the Ohio WIC program and the Farmers Market Nutrition Program. WIC is 100 percent federally funded through the United States Department of Agriculture. BNS administers the WIC program through 75 local agencies with 230 clinics throughout Ohio's 88 counties. Ohio is among the ten largest WIC programs in the United States and one of the largest in the Midwest. The Ohio WIC program provides highly nutritious foods, nutrition and breastfeeding education and support, immunization screening, and health care referral through local agencies to eligible individuals. The WIC program coordinates with BCFHS for smoking cessation and lead prevention awareness.

Help Me Grow (HMG): The DFCHS Bureau of Early Intervention Services (BEIS) administers a birth to three program serving pregnant women, newborns, and infants and toddlers and their families. HMG includes enabling and population based services including home visits to pregnant women, first time and teen moms, and which promote outreach to women to seek early prenatal care. See further description of HMG below.

Services for Infants and Young Children
Child and Family Health Services Program (CFHS): The child health services component of the CFHS program (described above) provides direct, enabling, population and infrastructure services to low income un/underinsured infants and children.

Help Me Grow (HMG):The Bureau of Early Intervention Services (BEIS) administers programs to promote early identification and intervention services for young children. Most of the programs are funded through sources other than the MCH BG, such as state General Revenue Funds, the U.S. Department of Education, and other federal grants from the U.S. Department of HHS. BEIS administers the Part C Early Intervention Program, which has been integrated into a larger initiative called the Help Me Grow Program, which includes services for at-risk families with infants and toddlers and a newborn visitation program. HMG will continue to provide important information on

prenatal and infant care and development, positive parenting, safety, and abuse prevention In SFY 2004, the HMG program visited over 31,000 newborn and their families; and provided supports and services to over 34,000 infants and toddlers at-risk for or with developmental disabilities.

Healthy Child Care Ohio: The BEIS also administers the Healthy Child Care Ohio project in partnership with the Ohio Child Care Resource and Referral Association. Registered nurses provide health and safety consultation and training to child care providers, screen pre-school children for vision problems, and work in partnership with the Bureau of Child Care and Development at the Ohio Department of Job and Family Services as a resource to child care providers as they implement quality improvement activities to achieve a higher ranking in a newly created tiered rating system for child care providers.

Universal Newborn Hearing Screening/Infant Hearing Program: In July 2004, the birthing hospitals in Ohio began screening all newborns for hearing loss prior to hospital discharge. Each newborn is screened using a physiologic test and results are reported to the parents and newborn's primary care provider. Babies who do not pass the two-part screen are referred to the regional infant hearing program (nine regional projects) for follow-up and In July 2004, the birthing hospitals in Ohio began screening all newborns for hearing loss referral to the HMG program if a hearing loss is confirmed. Ohio anticipates that approximately 400-500 infants with hearing loss will be identified each year through this process.

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC): WIC provides the enabling services of nutritional help during critical times of growth and development to prevent health problems and improve the health status of eligible individuals. WIC takes the lead in DFCHS in promoting breastfeeding. WIC has partnered with the Ohio Department of Education and Ohio Head Start to distribute 2,000 Ohio WIC Health Heroes Videos to promote child wellness. The videos provide five messages on healthy eating, oral health, safety and physical activity. WIC also has implemented the WIC Healthy Children Ready to Read Initiative: To facilitate and encourage reading readiness among WIC children while teaching children about good nutrition, 30,000 "Give Me 5 a Day" books are being distributed.

Oral Health Services: The DFCHS Bureau of Oral Health Services (BOHS) provides population and infrastructure activities to improve the oral health of young children. BOHS provided leadership to the development of a statewide Head Start Oral Health Strategic Plan. BOHS collaborated with the Ohio Head Start Association and others on this project and continues to convene and support a steering committee focused on implementing the plan. BOHS has three separate contracts with local agencies and organizations to develop models for Head Start oral health technical assistance and for increasing the number of primary care dentists willing to treat Head Start children. BOHS has contracts with two universities to train safety net dental clinic staff on providing dental care for young children and training home visitors on oral health needs and establishing linkages to dental homes for young children. The latter pilot program is called "Help Me Smile." It interfaces with the HMG program, WIC clinics and Community Healthcare Worker programs. The purpose of the project is to train home visitors, WIC health professionals and others who work with families of very young children.

Ohio Childhood Lead Poisoning Prevention Program (OCLPPP): The CDC-supported OCLPPP is a comprehensive population based lead poisoning prevention program. OCLPPP is the collection point for all blood lead analysis performed on Ohio residents. The data are reported weekly in an electronic format and either held in this program or forwarded to the ABLES program (Surveillance). The OCLPPP is required by statute to complete public health lead investigations on all children in its jurisdiction who have a confirmed blood lead level of 10 mcg/dl of whole blood or greater. The OCLPPP provides lead poisoning prevention education to medical and public health providers through the Pediatric Lead Assessment Network Education Training (PLANET) program. The OCLPPP funds its three Regional Resource Centers by using Title V funds for technical assistance to local providers and families on the importance of screening, public awareness, and maintenance of local collaboratives to prevent lead poisoning of children. The OCLPPP funds six local jurisdictions to

facilitate comprehensive Childhood Lead Programs in their local communities.

Sudden Infant Death Program (SID): The SID Program supports population based activities that assure compliance with an Ohio statute related to reporting of SIDS and the provision of support and bereavement services. Through a grant, ODH partners with the SID Network of Ohio to be the state's agent for the SIDS program. The SID Network has responsibility for receiving from coroners the Notification of Infant Death. The SID Network notifies the local health district; mails a packet of SIDS information and bereavement resources to the family; notifies the local network support affiliate; provides training to public health nurses on making a home visit to families; and serves as a resource for SIDS and risk reduction information for local health departments and other agencies or individuals. Since 2002 the SID Network of Ohio has implemented a community-based African American outreach campaign to reduce the risk of SIDS in the minority population.

Save Our Sight Program (SOS): The population based SOS Program is a state statute to ensure that children in Ohio have good vision and healthy eyes. The SOS Fund was created with the purpose of providing funding, technical assistance and support to 501 (c) organizations delivering children's vision services in all Ohio counties. The funds are generated by voluntary contributions by citizens of Ohio registering their motor vehicle and/or renewing their license plate(s) and are administered by ODH. These funds support organizations to 1) provide training, certification and equipment for voluntary children's vision screeners; 2) provide protective eyewear for youth sports and school activities; 3) develop and provide eye health and safety programs in schools; and 4) implement an Amblyope Registry.

Services for School-Aged Children and Adolescents
Child and Family Health Services Program (CFHS): The child health services component of the CFHS program (described above) provides direct, enabling, population and infrastructure services to low income un/underinsured children and adolescents.

Save Our Sight Program (SOS): See description above.

School Nursing Consultation: DFCHS school nurse consultants provide infrastructure services in the form of consultation, technical assistance and continuing education for school nurses. The school nurse consultants provide assistance to the Ohio Department of Education on accreditation requirements for school nurses and offer direction for state policies related to the school nursing care of CSHCN. Various technical assistance documents and guidelines have been created for school nurse issues to assist in developing standards for school screenings, delegation of medication issues, management of school health records and management of chronic illness of school students. Regional trainings to all school nurses in Ohio are provided on topics such as HIPPA, Bioterrorism, SARS and current school based mental health programs. Additional technical assistance and training is delivered to school nurses through the development of web based continuing education modules. ODH "Guidelines on BMI for Age" were developed to help local health departments and schools collect this information accurately. DFCHS collaborated with the ODH Homeland Security Program and has received funds to develop school based training for emergency preparedness in schools.

Adolescent Health Programs: DFCHS provides population-based and infrastructure services to improve the health of adolescents through its Adolescent Health Program. A statewide adolescent health advisory committee comprised of physicians, university personnel, adolescent wellness coordinators and interested parents and teens help to direct the program efforts of the adolescent program. The adolescent health coordinator is develops technical assistance materials for local health departments and funded grantees who work with adolescents. Regional trainings for local health care providers on adolescent development is an ongoing training program. Other efforts include training health care staff in identifying mental health resources for referral and treatment of adolescents who present with depression and anxiety disorders.

In an effort to improve health of the school aged child, the DFCHS School and Adolescent Health program, in collaboration with the ODH Division of Prevention developed the Healthy Ohioan's-

Governor's Buckeye Best Healthy School Awards Program which recognizes schools whose programs and policies reflect a high priority on nutrition, physical activity and tobacco education programs. The Buckeye Best program assists local schools in assessing their school environment and provides technical assistance to schools to improve the health of the students and staff. Programs focus on improving school nutrition, adding more physical activity and tobacco education. The Adolescent Health Program coordinates the implementation of the Youth Risk Behavior Survey in Ohio. In collaboration with the DFCHS Research and Evaluation Section, the Adolescent Health Program has developed a report entitled "The Health of Ohio's Adolescents, 21 Critical Indicators". This report, framed after the national adolescent health initiative, presents Ohio and national data on the 21 critical indicators that have been identified by the nation's adolescent health experts that critically impact the health of adolescents.

Services for Children with Special Health Care Needs
Overview of Title V CSHCN Program: The Bureau for Children with Medical Handicaps (BCMH) has five programs that provide direct, enabling, population based and infrastructure services to CSHCN. 1)The Diagnostic Program serves children from birth to the age of 21 to rule out a medically handicapping condition, to diagnose a condition, and to develop a plan of treatment for the child. There is no financial eligibility for this program; 2) The Treatment Program provides ongoing treatment services for eligible children. It serves children from birth to the age of 21 who have a chronic medically handicapping condition for which there is a medical treatment. Families must also meet the financial eligibility for this program; 3) The Hospital Based Service Coordination Program supports team based service coordination for conditions such as Spina Bifida and Hemophilia. There is no financial eligibility test for this program. The purpose of the program is to link families to services in the tertiary center and to link them back to their community; 4) Community Based Service Coordination Program supports Public Health Nurses in the Local Health Departments who assist families in linking to local resources and help families navigate the complex health care system; 5) Medical Home for CSHCN Program supports the efforts of local physicians to be Medical Homes for CSHCN. This is accomplished by reimbursing for care coordination codes and supporting office based service coordination. The Title V CSHCN Program also houses four genetics programs.

The Title V CSHCN program is continuing to face the challenge of decreasing funding and increasing need. Ohio is now in its Biennium Budget Process and the legislature may make changes to the program through the budget process. In the past year the program has increased its commitment to service coordination by supporting service coordination for children with sickle cell anemia and for young adults transitioning from pediatric to adult health care systems. The program is supporting the medical home for all children and especially CSHCN. The Title V program continues to closely network with the Medicaid and Early Intervention programs. The BCMH and the Bureau for Managed Health Care co-sponsored six regional meetings with emphasis on Transition Issues, the Medical Home, and the CSHCN Survey Results. The Title V program for CSHCN is implementing a new electronic medical record system which will aid greatly in the matching of CSHCN with services.

Genetic Services Program: ODH provides funding to 8 Regional Comprehensive Genetic Centers (RCGC) to ensure and enhance the accessibility and availability of quality, comprehensive genetic services to all Ohioans. Services include genetic counseling, education, diagnosis and treatment for individuals of all ages. The Genetics Services Program is striving to integrate genetics in public health programs through activities conducted through the ODH grants each year. Currently RCGCs focus activities on educating primary care providers about newborn screening and working with local cancer centers and chapters of the American Cancer Society.

Sickle Cell Services Program: ODH funds two sickle cell initiatives: Regional Sickle Cell Services Projects and Statewide Sickle Cell Family Support Initiative. ODH funds six Regional Sickle Cell Services Projects throughout the state to ensure and enhance the availability and accessibility of quality, comprehensive services for newborns, children and adults with, or at risk for sickle cell disease, sickle cell trait and related hemoglobin disorders in Ohio. Services include newborn hemoglobin screening follow-up; hemoglobin counseling; outreach education; adolescent to adult care transition; referral services for diagnosis, treatment and management. ODH funds one Statewide

Sickle Cell Family Support Initiative to support statewide family education and training programs; patient/client advocacy; supportive interventions; referral services; and public awareness and media campaigns. Projects provided services to residents of 73 of Ohio's 88 counties.

Metabolic Formula Program: ODH provides metabolic formula to individuals of all ages in Ohio with phenylketonuria (PKU) and homocystinuria who are under the care of an approved metabolic specialist. ODH provides metabolic formula to approximately 260 individuals each year. Metabolic formula is very expensive and many pharmacies will not order it for patients who need it. In addition, less than 25% of insurance plans in Ohio will cover metabolic formula.

Birth Defects Information System (BDIS):Ohio has legislation authorizing the ODH to develop and implement a BDIS. With the award of CDC funding in 2003, plans for development of the system began. In Ohio, the BDIS has been named the Ohio Connections for Children with Special Needs. Administrative rules have been approved and a data collection pilot project will take place in 2005. The goal of the project is to design and implement a system for reporting children 0-5 years with identified birth defects and make referrals to services for the families to ensure they are aware of services available that may improve their child's quality of life or outcome. There is a partnership agreement between ODH and the March of Dimes to reduce the burden of birth defects in Ohio.

Specialty Medical Services Program (SMSP): The SMSP provides clinical services for children in 52 counties in Ohio. The 5 types of clinics, Developmental, Hearing, Neurology, Orthopedic and Vision, improve access for low-income children to pediatric specialists in medically underserved areas. Both diagnosis and treatment services are provided through these itinerant clinics. These "safety net" clinics supplement the private practice system in providing access points for patients. The clinical services are provided through a contractual arrangement with providers and ODH. The itinerant clinics are based primarily in local health departments through a contractual agreement. Local Public Health Nurses assist families in applying for Medicaid and BCMH and help families make follow-up appointments for other testing or surgery. The majority of the clinics are provided in Rural-Appalachian counties located in the southeastern region of the state due to lack of specialty providers.

Other Infrastructure Activities.
Data Collection and Analysis: Described in Section F: State Health Capacity Indicators 09A, B and C.

Capacity to Provide Culturally Competent Care for Ohio's MCH Population: All CFHS, Women's Health Services, Family Planning, and OIMRI grantees must complete the Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards self-assessment tool, based on the 14 national CLAS standards.

C. ORGANIZATIONAL STRUCTURE

C. Organizational Structure

The Ohio Department of Health (ODH) is designated as the State agency responsible for administration of the Title V Maternal and Child Health Block Grant (MCH BG).

Director J. Nick Baird, M.D., of the ODH is one of twenty-six directors or appointees who serve at the pleasure of Governor Bob Taft. Governor Taft is currently in the third year of his second term as Governor of Ohio. Dr. Baird, an obstetrician-gynecologist who has been with the ODH since 1999, has extensive experience working as an administrator within a large health care system.

ODH is organized by function with nearly all programs in the department housed within three divisions (Organizational charts for the Department and for each Division can be found at the following URL: http://www.odh.state.oh.us/About/Org/Charts/orgmain1.htm. Organizational charts for the Department and for the Division of Family and Community Health Services, which administers the MCH Block Grant, are attached to this document.) All three divisions within ODH are under the supervision of

Anne Harnish, the Assistant Director of Health who has in the past worked with the administration of the MCH Block Grant, served as Chief of the Bureau of WIC and as an advocate with the Ohio Office of the Children's Defense Fund.

Nearly all the Title V MCH BG funded programs and positions (including the state's Children with Special Health Care Needs Program) are under the supervision of the Ohio Title V Director, David P. Schor, MD, MPH, FAAP, Chief of the Division of Family and Community Health Services (DFCHS). Some Title V MCH BG dollars are transferred to the Division of Prevention, one of the other two divisions within the department, for administration of the Women's Health Program. The Abstinence Only Education Program is administered in the ODH Director's office.

Dr. Schor directs the work of the following seven bureaus in DFCHS: Bureau of Child and Family Health Services (BCFHS), Bureau for Children with Medical Handicaps (BCMH), Bureau of Community Health Services and Systems Development (BCHSSD), Bureau of Early Intervention Services (BEIS), Bureau of Health Services Information and Operational Support (BHSIOS), Bureau of Nutrition Services (BNS), and Bureau of Oral Health Services (BOHS).

Dr. Schor is assisted by a Medical Advisor, Virginia Haller, M.D. Dr. Haller is a pediatrician and formulates medical policy as advisor to the Division Chief, and represents the Division and the Department on issues related to family and community services. She lectures on pediatric and public health topics, serves as Divisional liaison with ODH Prevention Injury Program and Departmental liaison to the state Trauma Committee, and coordinates medical resident and student rotations.

Bureaus in the Division of Family and Community Health Services
BCFHS is responsible for administering the following programs: Title X Family Planning; Women's Health, Child and Family Health Services (family planning, perinatal, well child services, and infant mortality reduction); lead poisoning prevention; prenatal tobacco cessation; pediatric specialty services; Regional Perinatal Centers; Save Our Sight Vision Programs; Child Fatality Review; and Sudden Infant Death Program.

BCFHS has a contract with Cynthia Shellhaas, M.D., MPH to provide medical consultation to bureau program areas serving pregnant women, children and families. Dr. Shellhaas is a licensed OB/GYN specializing in maternal-fetal medicine (high risk obstetrics) and holds a full-time faculty position in the Ohio State University's department of Obstetrics and Gynecology.

BCHSSD administers a variety of programs designed to improve access to health care services for vulnerable populations. The Primary Care and Rural Health Program provides funding for primary care services for uninsured populations of children and pregnant women, places health care providers via six different placement programs in underserved areas, submits Health Professional Shortage designation applications for primary care, mental and dental health underserved areas of Ohio, provides funds to support rural hospitals achieve Critical Access designation and provides 30 small rural hospitals infrastructure building support for quality improvement and networking systems development. In addition BCHSSD provides community assessment data including the 88 county profiles of a statewide analysis of primary care unmet need, the 21+ Critical Indicators of Adolescent Health in collaboration with BHSIOS and is gathering baseline data to establish county level BMI data for third graders to assist communities measure the impact of their efforts to prevent the consequences of the obesity epidemic. The School and Adolescent Health programs funded by Title V orient, provide regional annual trainings and consultation for the population of approximately 1200 school nurses throughout the state and implements the Governor's Buckeye Best schools awards program which recognizes schools' achievements in promoting physical activity, nutrition and tobacco prevention. BCHSSD also manages the Black Lung Disease Program the SEARCH program that recruits health care provider students to work in underserved areas and the Ryan White Title II Program which provides funding for health care, medications and support systems to approximately 7,500 HIV+ Ohioans.

BCMH administers five programs to serve children with special health care needs (CSHCN):

Diagnostic Program; Treatment Program; Hospital Based Service Coordination Program, supporting Team Based Service Coordination for conditions such as Spina Bifida and Hemophilia; Community Based Service Coordination, supporting Public Health Nurses in the Local Health Departments who assist families in linking to local resources and help families navigate the complex health care system; and Medical Home for CSHCN, supporting the efforts of local physicians to be Medical Homes for CSHCN. The Title V CSHCN Program also houses four programs in the Genetics Section: Genetic Services Program, Sickle Cell Services Program, Metabolic Formula, and Birth Defects Information System (BDIS).

BEIS is responsible for the administration of several programs serving young children (primarily birth to three) and their families. The Help Me Grow program provides information, services and supports to pregnant women, new parents, and to infants and toddlers at risk for or with developmental disabilities and their families. BEIS also administers the Healthy Child Care Ohio grant for health consultation by registered nurses to child care providers; the Newborn Infant Hearing Program; and the State Early Childhood Comprehensive Systems Grant. While most funding for these programs comes from sources other than the MCH BG, all of these programs work collaboratively with the Title V funded programs to improve the health of infants, young children and their families.

BNS is responsible for administration of the USDA funded Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), as well as a Farmer's Market Nutrition program. The Ohio WIC program provides highly nutritious foods, nutrition and breastfeeding education and support, immunization screening, and health care referral through local agencies to eligible individuals. WIC helps income-eligible pregnant, postpartum, and breastfeeding women, infants, and children who are at special risk with respect to physical and mental health due to inadequate nutrition, health care, or both. WIC works collaboratively on Title V initiatives for improving the health status of pregnant and breastfeeding women, infants and young children.

BOHS supports local agencies with grant funding to provide dental care services (primary care and dental sealants) to high risk children and women of childbearing age. The Bureau also develops program and training materials and provides technical assistance and monitoring to other DFCHS programs such as BCFHS clinics, BNS, Head Start, local schools and other public health related programs. Communities are assisted in conducting oral health needs assessments and developing sites for providing primary dental care services. This assistance includes making application for federal designation as a Dental Health Professional Shortage Area. The BOHS improves access to dental health care through the OPTIONS Program (Ohio Partnership to Improve Oral Health through access to Needed Services). The program links uninsured, low income patients with safety net dental programs, or a network of dentists who agree to either donate or significantly discount their fees.

BHSIOS is responsible for the provision of support services to all program areas within DFCHS. The Research and Evaluation Section provides data analysis, program planning and evaluation assistance through the utilization of epidemiologists and researchers. Other sections within the BHSIOS provide grants processing support and purchasing/fiscal support to Division programs as well coordination with the computer-based technological support services in the department. The State Systems Development Initiative (SSDI) and Pregnancy Risk Assessment Monitoring System (PRAMS) are administered in BHSIOS. Three researchers from the ODH Center for Vital and Health Statistics joined the BHSIOS in 2005. This enhanced research capacity will be used to increase analytical capacity in the areas of minority health data gaps, Medicaid data analysis, and the analysis of the 2004 Ohio Family Health Survey.

Title V Support in the ODH Division of Prevention
In the ODH Division of Prevention, Bureau of Infection Control, the Immunization Unit, serves as the lead for statewide immunization services and develops the State Immunization Action Plan. The Injury Prevention Program in the Bureau of Health Promotion and Risk Reduction serves as the lead for injury programming; and the Bureau's Women's Health Program receives MCH BG funding for one staff position. The ODH Laboratory, responsible for Newborn Metabolic Screening and follow up, is also housed in the Division of Prevention. The Title V program coordinates with the all these areas to

implement MCH BG strategies related to immunization, deaths due to motor vehicle crashes, and women's health issues, including domestic violence activities. The Title V program also coordinates activities with the Division of Prevention related to the primary and secondary prevention of chronic diseases (e.g., asthma, diabetes, heart disease) in school settings.

D. OTHER MCH CAPACITY

D. Other MCH Capacity
Just over 200 positions within ODH are either fully or partially supported by the MCH Block Grant (MCH BG). Sixteen of these positions are housed in ODH District Offices; the rest are Central Office-based in Columbus.

The BCMH employs a Parent Advocate, Kathy Bachmann, who works closely with the BCMH Parent Advisory Council and is involved in all Bureau decision making. She works as a liaison between families and BCMH. She provides information about BCMH to families, and brings the family perspective to BCMH Program leadership. Parents are involved on most Bureau committees. BCMH has developed regional youth advisory councils which advise the Bureau on how to address the transition from youth to young adult. In addition, the BEIS provides funding through Part C of IDEA to establish family support activities within the Help Me Grow (Birth to Three Program).

Ruth Shock is the MCH BG and Needs Assessment Coordinator; the SSDI Coordinator, and the Data Contact for all MCH BG issues. MCH Block Grant Coordinator activities are incorporated into the position description of the Research and Evaluation Section Administrator, DFCHS Bureau of Health Services Information and Operational Support. Responsibilities include coordinating the various aspects of the MCH BG application, coordinating the Need Assessment, as well as provide training on MCH issues such as program planning and evaluation.

Brief biographies of Division of Family and Community Health Services leadership:

David P. Schor
Division Chief
M.D., M.P.H., F.A.A.P.
Experience: Dr Schor is a board-certified pediatrician with training and experience in developmental and behavioral pediatrics who joined the Ohio Department of Health as division chief in January, 2002. He formerly served as MCH director, medical advisor, and director of health promotion with the Nebraska Department of Health and Human Services (1991-2001) Prior to his tenure with the department of health, Dr. Schor served on the staff of the department of pediatrics for both Temple University School of Medicine (1987-1991) and the University of Iowa School of Medicine (1980-1987). Dr. Schor received his bachelors degree in biology from the California Institute of Technology and graduated from medical school at Case Western Reserve University in Cleveland. He received a masters of public health from the University of Michigan in 1994.
Duties: Establish policy, standards and guidelines for the MCH programs and staff; directs the development of program budgets and resource allocations; reviews legislation impacting the MCH program and population served; integrates MCH program objectives with other ODH programs and other State agencies; and manages the daily operation of the Division. He is a former regional counselor for AMCHP, served on the ASTHO committee that produced the Genomics Toolkit for Public Health published in June, 2003, and is currently a member of the Committee on Poison Prevention and Control (Institute of Medicine, National Academies).

Virginia A. Haller
Medical Advisor, ODH (changed to reflect the arrival of Dr. Schor as Division Chief and the role Dr. Haller plays outside the Division of Family and Community Health Services)
B.A. Biology, Music; M.D., F.A.A.P.
Experience: 3 years Medical Advisor, DFCHS; 13 years Clinical Associate Professor of Pediatrics, OSU; 3 years Medical Director DFCHS; 1.5 years Medical Director, Ohio Department of Health; 2.5 years Medical Director, United HealthCare of Ohio, Inc.; 7 year member of the Franklin County Alcohol, Drug Addiction and Mental Health Services Board; 7 years, Chief and Medical Consultant, Bureau of Maternal and Child Health; 1 year Chair, Ohio Task Force on Drug-Exposed Infants; 2 years Chair, Ohio Compassionate Care Task Force.
Duties: Formulates medical policy as advisor to the Division Chief, represents the Division and the Department on issues related to family and community services. Lectures on pediatric and public health topics; serves as Divisional liaison with ODH Prevention Injury Program and Departmental liaison to the state Trauma Committee, coordinates medical resident and student rotations.

Bureau of Child and Family Health Services
Karen Hughes, Bureau Chief
B.S. Education; R.D.H.; M.P.H.
Experience: 14 years BCFHS Chief
Duties: Directs the Bureau of Child and Family Health Services programs, including Child and Family Health Services; Family Planning; Women's Health Services; Ohio Infant Mortality Reduction Initiative; Prenatal Smoking Cessation; Regional Perinatal Centers Program; Ohio Childhood Lead Poisoning Prevention; Save Our Sight; Pediatric Specialty Clinics (Developmental, Hearing, Neurology, Orthopedic, Plastic, Vision); Child Fatality Review; and Sudden Infant Death (SID). Co-directs Community Access and Medicaid Administrative Match Programs.

Bureau for Children with Medical Handicaps
James Bryant
Bureau Chief and Medical Director
B.S. Biology; M.D.; F.A.A.P.; Pursuing Masters degree in medical management
Experience: 29 years general practice of pediatric medicine with emphasis on CSHCN; 10 years Chief and Medical Director of BCMH; Associate Professor of Pediatrics, Wright State University School of Medicine; Director at Large of AMCHP.
Duties: Develop standards, implement programs and direct the CSHCN program; supervise state CSHCN personnel; serve on appropriate boards and advisory groups including Ohio Developmental Disabilities Planning Council; serve on state and federal committees dealing with CSHCN issues.

Bureau of Community Health Services and Systems Development
Jamie Blair
Bureau Chief
B.S. Nursing; M.S. Psychiatric and Mental Health Nursing; APRN BC
Experience: 7 years BCHSSD Chief; 7.5 years Certified Community Health Nursing Specialist, 15 years certified in pediatrics and 6 years certified as nurse case manager; 5 years certified in school nursing; 30 years of progressive experience including: program development, strategic planning, health care delivery, patient assessment, case management, research and evaluation, patient advocacy, standards development and training.
Duties: Directs the assessment, planning, implementation, policy development and evaluation of statewide programs including the offices of Primary Care and Rural Health (including 6 health care provider programs), Black Lung, Ryan White Care Title II services, School and Adolescent Health Services, and the activities of the Strategic Planning Section including initiatives to improve health care access for underserved populations.

Bureau of Early Intervention Services
Debra Wright
Bureau Chief
BS Nursing; MS Nursing Administration; Pursuing MS degree in Family Nurse Practitioner program

Experience: 6.5 years as bureau chief; 4.5 years as program administrator; 2 years as genetics nurse consultant; 2 years in public health nursing; and 11 years experience in obstetrical, neonatal and pediatric nursing.
Duties: Directs the planning, development, implementation and evaluation of Bureau programs which focus on families with infants and toddlers (Help Me Grow program to include Part C of IDEA; Infant Hearing Screening program; and Healthy Child Care Ohio program); and coordinating interagency efforts around a state plan for Early Childhood systems which address medical home, family support, parent education and social-emotional development of young children.

Bureau of Health Services Information and Operational Support
Bill Ramsini
Bureau Chief
Ph.D. Agricultural Education
Experience; 19 years of experience in the area of health care data collection and analysis. Chief, Center for Vital and Health Statistics; Bureau Chief, Division of Family and Community Health Services.
Duties: Directs the work of BHSIOS which provides support to all other DFCHS bureaus in research and evaluation, information systems and operational support. Overseas the State Systems Development Initiative, the Pregnancy Risk Assessment Monitoring System (PRAMS), and coordinates the data cooperation between, ODH, Ohio Department of Job and Family Services, and Ohio Hospital Association.

Bureau of Nutrition Services
Michele A. Frizzell
Bureau Chief
BS in Dietetics; Registered Dietitian; Master in Business
Effective April 4, 2005, Michele Frizzell is Chief of the Bureau of Nutrition Services. Experience: Over 20 years of diverse public service experience, most recently at the Ohio Department of Alcohol and Drug Addiction Services (ODADAS), where she managed the quality improvement initiatives for a number of ODADAS statewide programs. For the ten years prior to her work at ODADAS, she held a number of positions in the ODH WIC Program, including program consultant, administrator of program support, and system redesign project manager.

Bureau of Oral Health Services
Mark Siegal
Bureau Chief
D.D.S.; M.P.H.; Certificate in Pediatric Dentistry; Certificate in Dental Public Health; Diplomate of the American Board of Dental Public Health and a past-president of the Ohio Academy of Pediatric Dentistry.
Experience: 18 years Chief; 2 years Columbus City Health Department Dental Director; 4 years Hospital Director for Pediatric Dental Services; 4 years New Mexico Health District Dental Director.
Duties: Directs the Bureau of Oral Health Services' activities toward improving the oral health of Ohioans by assessing needs, implementing community-based disease prevention and health promotion and increasing access to dental care. Maintains a liaison role with professional associations and other agencies on policy development and other collaborative efforts.

E. STATE AGENCY COORDINATION

E. State Agency Coordination
The Ohio Title V Program, administered entirely within the ODH, has strong collaborative relationships with other state agencies, local health departments, other local public heath agencies, academic programs and professional associations to improve the health of the MCH and CSHCN population.

Collaborations with Other State Agencies
Ohio Family and Children First (OFCF): OFCF is a collaborative effort of the state's education, health, and social service systems with Ohio families, concentrated on achieving the shared policy goal of ensuring that all children are safe, healthy and ready to learn. This partnership is critical because no single state system has the resources or capacity to meet this goal alone. Oversight of the initiative is provided by the Family and Children First Cabinet Council. Members of the Cabinet Council include agency directors of Education; Alcohol and Drug Addiction Services; Budget and Management; Health; Job and Family Services; Mental Health; Mental Retardation and Developmental Disabilities; Aging; and Youth Services. The DFCHS Chief serves on the OFCF Deputies Committee to ensure a system-wide implementation of all OFCF priorities and activities.

Each of Ohio's 88 counties has created a Family and Children First Council. Local council membership includes families, representatives of public agencies, schools, courts and private providers. Each council is responsible for determining local strategies to achieve school readiness and to address a shared commitment to child well-being which include: expectant parents and newborns thrive, infants and toddlers thrive, children are ready for school, children and youth succeed in school, youth choose healthy behaviors, and youth successfully transition into adulthood.

Ohio Department of Job and Family Services (ODJFS): ODJFS develops and oversees programs that provide health care, employment and economic assistance, child support, and services to families and children. ODJFS also administers the Medicaid program. Ohio's Title V program has ten MCH/CSHCN-related interagency agreements with ODJFHS as follows:

1) An agreement links Title V and Title XIX services for the purpose of coordinating health services and conducting outreach, program eligibility and payment for services for Ohio mothers and children as defined and specified in 42 USC section 701, et. al., and 7 CFR Part 246.The agreement coordinates the exchange of information and referral among the local Child and Family Health Services projects (CFHS), WIC, Help Me Grow programs, Offices of Primary Care and Rural Health, and the Ohio Medicaid programs.

2) An agreement on environmental lead risk assessment done in homes of Medicaid-eligible children with blood lead levels greater than or equal to15 ug/dL includes the provision of written recommendations to HEALTHCHEK (EPSDT) Coordinators who request assistance with housing relocation.

3) An agreement on the relationship and responsibility for data sharing and analysis on blood lead screening on Medicaid-eligible children and other lead-related information is used to enhance services, and give county coordinators better information.

4) An agreement reimburses ODH for a portion of the administrative costs of technical assistance and training of local providers of the Help Me Grow program. A large portion of funding for the statewide program is provided through Temporary Assistance to Needy Families (TANF) dollars.

5) An agreement reimburses ODH for the costs associated with developmental evaluations conducted by Help Me Grow (HMG) providers as a result of new federal requirements in "The Keeping Children and Families Safe Act of 2003" which requires all children under the age of three who are involved in a substantiated report of child abuse and/or neglect to be referred to early intervention services provided by ODH through the HMG program.

6) An agreement reimbursing ODH for costs associated with the development of brochures and materials, and training on communicable diseases, first aid, medication administration, back-to-sleep, developmental screening and inclusive child care as part of a health and safety training curriculum for child care providers and trainers.

7) An agreement on a statewide immunization and MMIS interface creates an interface between ODJFS and ODH to share immunization records.

8) An agreement defines relationships and responsibilities between ODJFS and ODH for the conduct of desk reviews, interim settlements, field audits, and final settlements for ODH's Bureau for Children with Medical Handicaps (BCMH). The agreement meets the requirements of Title V for financial accountability and administration of BCMH.

9) An agreement provides funding for an annual training session required for members of Child Fatality Review Boards (CFR). BCFHS coordinates with the ODJFS Children's Trust Fund Board on activities related to the CFR program, including the preparation and publishing of the CFR annual state report.

10) An agreement for data sharing and research projects of mutual interest related to the administration of Medicaid and the State Children's Health Insurance Program has produced information needed for MCH policy decisions.

In 2005 the Community Access Program funded by the Primary Care Bureau of HRSA provided the infrastructure to develop and pilot a Medicaid Administrative Claiming plan for the state which will provide a sustainable funding source for local health departments to continue to provide enabling services to vulnerable MCH populations.

The Bureau of Early Intervention Services (BEIS) collaborates with the ODJFS Bureau of Child Care and the Child Care Resource and Referral Association to expand the network of child care health consultants (RNs) to provide health and safety information to licensed child care providers. The ODH Healthy Child Care Ohio coordinator serves as an ex-offico member on the ODJFS Day Care Advisory Council, a legislatively mandated body that advises ODJFS on child care policy and implementation of child care law.

The DFCHS Medical Director sits on the Medicaid Medical Advisory Committee for the ODHS, and serves on the Executive Committee for that group.

ODH and ODJFS collaborated on the implementation of the second round of the Family Health Survey (OFHS) to address data gaps. ODJFS funded the project and ODH provided technical assistance. Approximately 40,000 telephone interviews were conducted in 2004 to gather data on risk factors, health status, unmet need, access to care, and health insurance status. The data are currently being analyzed.

The DFCHS Division Chief serves on the ODJFS Children's Trust Fund Board and BCFHS coordinates with the Trust Fund on activities related to the CFR program, including the preparation and publishing of the CFR annual state report.

Ohio Department of Education (ODE): Technical assistance and training are provided by DFCHS nutrition, oral health, nursing, and hearing and vision consultants to state Head Start Programs in collaboration with the Ohio Head Start Association, Inc. (OHSAI) and ODE. At the request of OHSAI and ODE, Division of Early Childhood Education, a state Head Start/WIC agreement designed to promote collaboration between the two programs in the areas of nutrition screening/assessment, education, referral, and recruitment has been signed. The Bureau of Nutrition Services (BNS) coordinates with ODE and with the Head Start Program for sharing WIC Ohio Healthy Heroes videos.

The Bureau of Community Health Services and Systems Development (BCHSSD) provides technical assistance to approximately 1,200 school nurses as they assist families and students to access primary care, mental health and dental health safety net services identified by the Primary Care Program to address unmet health care needs and to eliminate health disparities. BCHSSD successfully applied for Bioterrorism funding to add a second school nurse consultant to assist school with emergency preparedness for the school aged population.

The BCHSSD School and Adolescent Health (SAH) program has been helping ODE to improve

nutrition messages for school aged children, families and teachers with the expertise of a public health nutritionist who is funded by the MCH BG. The SAH program also works with randomly selected local school districts to administer the Youth Risk Behavior Survey. In collaboration with the Ohio Chapter of the American Cancer Society, SAH administers the Governor's Buckeye Best School awards program which recognizes schools for achievements in the areas of increasing physical activity, improving nutrition and preventing tobacco use. The school nursing supervisor in SAH worked collaboratively with ODE department of special education services to revise rules for providing clinical services to students with special health care needs.

The Help Me Grow program in BEIS collaborates with the Part B Special Education and 619 (Preschool) programs at ODE to assure that training and information to local programs and school districts are coordinated where necessary.

ODE sits on the ODH Lead Advisory Council, which is adding requirements for child care's school facilities to ensure lead safe environments.

Ohio Department of Alcohol and Drug Addiction Services (ODADAS)
An interagency steering committee (including parents, private organizations and ODADAS) co-chaired by the Title V director as ODH's representative, produced a "town meeting" discussing family impact of Fetal Alcohol Spectrum Disorders. The initiative, supported by the Office of the First Lady of Ohio, received SAMHSA funding to produce a strategic plan for enhanced prevention, recognition, and intervention services. A conference including keynotes from other states' programs is set for August, 2005.

Ohio Department of Mental Retardation and Developmental Disabilities (ODMRDD):
An agreement between ODH and ODMRDD confirms their intent to assist jointly in comprehensive planning and coordination for a statewide HMG system to include infants and toddlers with developmental delays and disabilities, as defined in Part C of the Individuals with Disabilities Act, and their families.

DFCHS staff serves on several interagency committees and the BCMH chief was the ODH representative on the Ohio Autism Taskforce which was staffed by ODMRDD.

Ohio Department of Mental Health (ODMH): Collaboration with ODMH happens on two levels: BEIS is working closely with the early childhood mental health (ECMH) initiative at ODMH on projects addressing early identification and referral of new mothers with postpartum depression and young children with potential social/emotional needs; and training providers on ways to work with families with young children with challenging behavior. BCHSSD continues to work on school based mental health initiatives by representing the school nurse perspective and has co-sponsored a state wide strategic planning session to develop a plan for increasing school based mental health programs in Ohio schools. Currently there are four pilot programs in four area school districts using the "Columbia Teen Screen" - Depression Screening Program.

Ohio Department of Rehabilitation and Correction (ODRC): BNS continues coordination with the ODRC for the Prison Nursery Program.

Ohio Environmental Protection Agency (OEPA): BNS continues coordination with the OEPA for the annual Sport Fish Consumption Advisory.

Ohio Disabilities Planning Council: The BCMH Chief represents ODH, DFCHS on the Ohio Developmental Disabilities Planning Council, serving on the Children's Committee and the Health Committee.

Collaboration with the Social Security Administration (SSA)
An agreement between SSA and ODH, BCMH establishes conditions under which SSA agrees to disclose information related to eligibility for and payment of Social Security benefits and/or

supplemental security income and special veterans benefits, including certain tax return information to ODH, BCMH for use in verifying income and eligibility.

Collaborations with Local Public Health Agencies/Local Health Initiatives
The DFCHS Chief and BCFHS Chief serve on the Executive Council of the Cleveland Healthy Family/Healthy Start federal project to reduce infant mortality and have been actively involved with this project throughout its history. Both also serve on the Executive Council of the Columbus Healthy Start Project and participated in developing the coordination proposal submitted to MCHB.

The BCMH has close working relationships with Local Health Departments (LHD) throughout the state and a representative from a LHD serves on the BCMH Medical Advisory Council (MAC). The BCMH has been working with Federally Qualified Health Centers throughout the state and is strengthening that relationship.

Collaborations with Federally Qualified Health Centers (FQHCs)
While the Primary Care and Rural Health programs (PCRH) are administered in ODH by the Title V Director, PCRH programs maintain many collaborative relationships with outside agencies and systems. PCRH programs take the lead for two Presidential Initiatives in Ohio -- the development and expansion of FQHCs, and the growth of the National Health Service Corps (NHSC). A coordinated effort is underway with the Ohio Primary Care Association (OPCA) to develop FQHCs in medically underserved areas. The NHSC Scholarship and Loan Repayment Programs assist in staffing Ohio FQHCs as well as other safety net provider sites located in underserved areas. In 2004, the Primary Care program partnered with the Ohio Academy of Family Physicians Foundation and the Statewide Area Health Education Centers to win the NHSC SEARCH contract for Ohio. The SEARCH program places primary care, dental and mental health students and residents in underserved areas as a long term recruitment strategy (See attached chart). The Primary Care Program partners with the Ohio Board of Regents to operate two loan repayment programs that provide incentives for local health care providers to practice in underserved areas. In 2004 the Osteopathic Heritage Foundation joined the partnership by supplying local funds for the retention of a dentist in Appalachian Ohio. The Ohio Rural Development Partnership (ORDP) developed a 501c3 organization, the Ohio Rural Partners (ORP), which is able to apply for and receive federal, foundation and other funding.

Other Partnerships
The ODH Title V Program works closely with related professional medical organizations through staff participation on numerous advisory boards and committees, and shares some committees with organizations.

The Ohio Hospital Association OHA: OHA is the membership and advocacy organization for most of Ohio's hospitals. OHA has developed a strong interest in its small and rural hospitals, and has created a Small and Rural Hospital Committee. In addition, the OHA has partnered with the State Office of Rural Health (SORH) in the development and implementation of the State Rural Hospital Flexibility Grant Program that enabled Ohio to begin designating Critical Access Hospitals (CAHs). Early in the development of this Program an advisory committee was created, with representation from OHA, the SORH, rural hospitals, the Ohio Primary Care Association, the Ohio State Health Network, Division of EMS, Ohio Rural Development Partnership, and others with an interest in strengthening the rural health infrastructure. The Flex Advisory Board meets quarterly, and since its inception this meeting has been hosted by the OHA. A total of 31 CAHs have been designated to date.

A memorandum of understanding for data sharing between the ODH and OHA was signed in 2003. ODH developed an agency agenda for data needed from OHA for research and reporting purposes and has and has received and analyzed OHA data.

Association of Children's Hospitals: The BCMH collaborates closely with the Ohio Association of Children's Hospitals OACH). The Association is a key member of the MCH Advisory Counsel, the Birth Defects Advisory Council, and serves on other advisory groups as requested. The OACH is a key partner and advocate for health care issues for all children and especially CSHCN.

Ohio Chapter/American Academy of Pediatrics (OC/AAP): OC/AAP shares the Children with Disabilities Subcommittee with the BCMH Medical Advisory Council. This subcommittee is made up of members from the private sector and several state agencies and deals with social and educational issues of CSHCN in addition to medical issues. The ODH DFCHS participates with the OC/AAP in the development of a long term strategic plan targeting mental health concerns for children and adolescents. The DFCHS Medical Director chairs the physician group which advises ODH on the recruitment of providers to participate in the statewide immunization registry. She also serves as liaison between ODH and the OC/AAPin regard to the immunization education program for physicians and nurses.

Ohio Section of ACOG: The BCFHS Bureau Chief attends Ohio Section of ACOG quarterly meetings to share information from ODH.

Ohio Rural Development Partnership: See discussion under "Collaborations with Federally Qualified Health Centers

Ohio Dental Association: BOHS partners with the Ohio Dental Association (ODA) to administer a statewide volunteer dental care program called Dental OPTIONS (Ohio Partnership To Improve Oral health through access to Needed Services). This dental referral and case management program matches clients with dentists who provide discounted or donated care in their offices. The Bureau Chief is a member of the ODA's SubCouncil on Access to Dental Care and Dental Specialty Councils. The SubCouncil successfully put forth resolutions supporting recommendations of the Director's Task Force on Access to Dental Care.

Ohio Head Start Association, Inc. (OHSAI): BNS has an interagency agreement with OHSAI for the purpose of program coordination. BOHS collaborates closely with the OHSAI and convenes the Head Start Oral Health Steering Committee on a regular basis. Among the other agencies and organizations on this group are ODJFS, the ODH BEIS, the State Head Start Collaboration Office, the Ohio Academy of Pediatric Dentistry, the ODA as well as numerous local groups.

Health Policy Institute of Ohio: BOHS is collaborating with the Health Policy Institute of Ohio in convening the Dental Workforce Roundtable, with representatives from dental schools, organized dentistry, dental hygiene and dental expanded functions: the state dental board, the primary care association and the Association of Ohio Health Commissioners. BOHS is actively represented on the Ohio Coalition for Oral Health, with local health departments, FQHCs, and the Ohio Primary Care Association.

Ohio Public Health Association (OPHA): BCHSSD assumed the lead to work with the OPHA Directors of Nursing Section and the Ohio Nurses Foundation to develop 17 web based continuing education modules in support of public health nurse workforce development. Eight of the modules were based on competencies developed by the Council on Linkages Between Academia and Public Health Practice. Five of the modules were designed for school nurses and four were designed to meet the learning needs of PHNs who supervise a new health care provider role in Ohio, Community Health Worker. All of the modules can be accessed at www.publichealthnurses.com. MCH BG funds supported the development of the project.

Other: BOHS staff works closely with the Anthem Foundation, the Osteopathic Heritage Foundations and the Sisters of Charity, three private foundations which are funding initiatives to increase access to dental care. BOHS staff is involved with over 13 community groups which have identified dental needs as a priority. These groups typically include local agencies such as: health departments, job and family services, WIC, EI, dental societies, community action agencies, and schools. BOHS also collaborates with the Association of State and Territorial Dental Directors (ASTDD), the Indian Health Services (IHS) and local dental clinics to develop a web-based safety net dental clinic manual to provide technical assistance on starting and operating a non-profit clinic. The manual went on-line in 2003.

The School and Adolescent Health (SAH) program is involved in the Ohio Action for Healthy Kids Initiative, which builds upon the Healthy Ohioans-Buckeye Best Program by working throughout the state to improve nutrition and physical activity in schools and after school programs. The SAH has been working with the Ohio Parks and Recreation Association to create or strengthen relationships among schools and their local Parks and Recreation entities to encourage more physical activity for our school aged youth.

F. HEALTH SYSTEMS CAPACITY INDICATORS

F: Health System Capacity Indicators

Ohio has reported on all the below indicators in the Forms Section of this application. All data have been reported.

#01 HEALTH SYSTEMS CAPACITY INDICATOR
The rate of children hospitalized for asthma (10,000 children less than five years of age) - Formerly Core Health Status Indicator #01 BCMH works closely with the ODH State Asthma program in assessing and collecting data on children with asthma in Ohio.

According to data from the Ohio Hospital Association, 32.9 percent pf children under the age of five years were hospitalized for asthma in 2003, up slightly from 2002.

The DFCHS collaborates closely with the ODH State Asthma Program. DFCHS serves on the Ohio Asthma Council. The BCMH Asthma Pilot is in its second year and in the pilot, pharmacists work with patients to increase medication compliance and to decrease ER visits and hospitalizations. ODH continues to collaborate with the Ohio Hospital Association and the Ohio Association of Children's Hospitals to obtain hospital discharge data on children with asthma.

#02 HEALTH SYSTEMS CAPACITY INDICATOR
The percent of Medicaid enrollees whose age is less than one year who received at least one initial periodic screen. - Formerly Core Health Status Indicator #02A

In 2003, 82.3 percent of Medicaid enrollees under the age of one year received at least one initial periodic screen, up slightly from 2002.

The Division of Family and Community Health Services (DFCHS) provides technical assistance in DFCHS funded projects to assist consumers in enrolling in Medicaid Healthy Start/Healthy Families, and accessing safety net services and health care services. As an example, the Division provided technical assistance to Child and Family Health Services projects on removing the major barriers to Medicaid enrollment that included: assisting clients in completing the Medicaid application; following-up to determine Medicaid enrollment status, reminding clients about enrollment before and during appointments; conducting community education on Medicaid enrollment. The Division collaborates with interdepartmental, state, local agencies and initiatives to provide technical assistance publicize and disseminate Healthy Start information to providers, consumers, and employers.

The BCHSSD Primary Care and Rural Health Section collects data about health services provided to children (including <1year old) women and pregnant women that are funded by earmarked state funds for these populations and funds for the same populations from the Health Priorities Trust Fund (Tobacco Trust). Primary Care and Rural Health also collects data from all primary care and specialist providers who are placed in underserved areas via 6 different provider placement programs (including Ohio Physician Loan Repayment program, J1 Visa program, National Health Service Corps

scholarship program.

#03 HEALTH SYSTEMS CAPACITY INDICATOR
The percent of State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year who received at least one periodic screen. - Formerly Core Health Status Indicator #02B

In 2003, 82.1 percent of State Children's Health Insurance Program (SCHIP) enrollees under the age of one year received at least one periodic screen, up slightly from 2002.

Refer to #02 as SCHIP is part of the Medicaid Program in Ohio.

#04 HEALTH SYSTEMS CAPACITY INDICATOR
The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index. - Formerly Core Health Status Indicator #03

In 2003, 86.9 percent of women with a live birth had a Kotelchuck Index of at least 80 percent. This is about the same as 2002.

The Kotelchuck Index combines two independent dimensions of prenatal care. It characterizes the timing of prenatal care initiation and the frequency of visits received after the initiation of prenatal care compared to ACOG recommendations. While the Kotelchuck Index is a valuable index in measuring the adequacy and timing of prenatal care, it does not measure the quality of prenatal care. The Division of Family and Community Health Services (DFCHS) recognizes the importance of the adequacy of prenatal care and has several program strategies to improve the measure. The DFCHS is funding and providing technical assistance to projects that employ community health workers to improve access to care through culturally competent care coordination. The DFCHS Bureau of Child and Family Health Services (BCFHS) is also committed to ensuring that culturally competent is provided in its CFHS funded perinatal clinics. All CFHS subgrantees are monitored in their capacity to provide culturally competent care. An analysis that was done two years ago revealed that many subgrantees do not provide ongoing cultural competency training for their providers and do not have access to training resources. As a result of this analysis, the DFCHS is working to provide technical assistance and training.

#05 HEALTH SYSTEMS CAPACITY INDICATOR
Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State. - Formerly Core Health Status Indicator #06

ODH typically receives information from the Medicaid Program in the Ohio Department of Job and Family Services. The Medicaid Program's data that was provided to ODH is one year in arrears because of ODH Vital Statistics delays in processing 2003 birth and death files. As in all prior years, however, outcomes for persons who are on Medicaid are worse than the population as a whole and those not on Medicaid.

The information is used by Title V programs, including CFHS, to identify and target higher risk populations for outreach and services.

The BCHSSD Primary Care and Rural Health program will be using Medicaid data to verify the performance of safety net health care providers placed in underserved areas to assure that they are providing health care services in their practice settings in proportions no less than the percent of Medicaid eligibility rates in their respective health professional shortage areas of placement.

#06 HEALTH SYSTEMS CAPACITY INDICATOR
The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (0 to 1), children, and pregnant women. - Formerly Core Health Status Indicator #07

The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (0 to 1), children, and pregnant women is currently 150 percent.

The Ohio Department of Job and Family Services, Medicaid Program, provides information on the poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (0 to 1), children, and pregnant women annually.

#07 HEALTH SYSTEMS CAPACITY INDICATOR
The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year. - Formerly Developmental Health Status Indicator #04

In 2003 45.6 percent of EPSDT eligible children aged 6 through 9 years received any dental services during the year. This is up from 40.6 percent in 2002.

ODH and ODJFS work collaboratively to generate an accurate report for this and other access to dental care indicators.

In an effort to improve the health systems capacity, ODH provides MCH BG funds ($.5M) and tobacco settlement monies ($1M) to fund the start-up and expansion of twelve local nonprofit dental clinics.

#08 HEALTH SYSTEMS CAPACITY INDICATOR
The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs Program." - Formerly Block Grant Performance Measure #1 BCMH works with the Regional SSI office to determine numbers for this indicator.

In 2003, 26.3 percent of State SSI beneficiaries less than 16 years old received rehabilitative services from the State Children with Special Health Care Needs Program. This is slightly less than the 27 percent who received services in 2002.

The Bureau for Children with Medical Handicaps (BCMH) works with the Regional SSI office to determine the compliance with this indicator. BCMH encourages participants in its program to apply for SSI when appropriate. BCMH has had an aggressive public awareness campaign with 105 local health departments, through Public Awareness contracts, to ensure that children with special health care needs are referred to SSI for evaluation of eligibility. In addition, BCMH has provided educational in-services, in partnership with local SSI staff, to field nurse consultants and local public health nurses. BCMH provided copies of the Social Security and SSI Benefits for Children with Disabilities booklet to the local health department nurses who work with the BCMH program.

#09(A) HEALTH SYSTEMS CAPACITY INDICATOR
The ability of States to assure that the Maternal and Child Health program and Title V agency have access to policy and program relevant information and data. - Formerly Core Health Status Indicator #08

The ability of Ohio to assure that the Maternal and Child Health program and Title V agency have access to policy and program relevant information and data is carried out through the State Systems Development Initiative (SSDI) grant. The goal of Ohio's SSDI grant for the period 10/1/2003-9/30/2006 is to assist in building infrastructure for comprehensive, community-based systems of care for all children and their families. This goal will be accomplished through a focus on the Title V Maternal and Child Health (MCH) Block Grant Health Systems Capacity Indicator #9(A), and will be addressed, over the three-year grant period, through seven project objectives:

1) To improve access to data linkages between Ohio birth records and Medicaid files; 2) To create data linkages between Ohio birth records and WIC eligibility files; 3) To obtain access to hospital

discharge data; 4) To increase analyses of data from the Pregnancy Risk Assessment Monitoring System (PRAMS); 5) To increase analyses of data from the Youth Risk Behavior Survey (YRBS); 6) To monitor opportunities for establishment or improvement in priority data linkages and access to priority data sets that are unable to be addressed in the current project period; and 7) to provide quality data for MCH Block Grant performance measures and five-year needs assessment.

Access to both Medicaid data and Ohio Hospital Association (OHA) data are being achieved through an interagency agreement (Medicaid) and a Memorandum of Understanding (OHA). ODH has for the first time linked WIC and birth certificate data. Ohio participates in both the CDC PRAMS and Youth Risk Behavior Surveys, and SSDI funds are used to pay for a contracted biostatistician to assist with statistical analysis of the data. SSDI staff participated in the MCH Five Year Needs Assessment to provide quality data.

In regard to coordination of activities, the SSDI Coordinator is also the Title V MCH Block Grant Coordinator, and is housed in the ODH Division of Family and Community Health Services (DFCHS), allowing for integration of Title V Block Grant activities with SSDI activities.

In regard to experience to date, coordinating committees that involve representatives from ODH (including SSDI), Medicaid, and OHA, have been established to oversee interagency agreements. Several Medicaid projects have been approved in the DFCHS. ODH has received data from OHA, and initial analyses have been completed. To examine the effect of WIC participation on birth outcomes, Ohio birth files have been linked with prenatal WIC records. Several in-depth analyses of PRAMS data have been done with SSDI resources have been used for YRBS. A process for creating linked infant birth/death files was developed in a previous SSDI budget year.

The single most significant achievement of the year has been progress toward the objective on linking WIC and birth certificate data: To create data linkages between Ohio birth records and WIC eligibility files to assist DFCHS in program planning and policy development. SSDI and WIC staff met to discuss analyses and uses of information from linking the WIC and birth files that could be used for policy development and program improvement. The first project agreed upon was an examination of the effect of prenatal WIC participation on birth outcomes. The SSDI epidemiologist linked Ohio's most recent birth files (2002) with prenatal WIC records for 2001 and 2002. A 90 percent match was achieved. Since Ohio's birth records are geocoded, the matched files were categorized by census block groups into three neighborhood types: low, medium, and high income levels. The outcomes for women on WIC in each neighborhood type were compared with the outcomes for women not on WIC. In low income neighborhoods, women in WIC were significantly less likely to have very low birth weight (VLBW), low birth weight (LBW), and preterm LBW than women not in WIC. These findings were presented at the 2004 MCH Epidemiology Conference and at the 2005 AMCHP Conference.

#09(B) HEALTH SYSTEMS CAPACITY INDICATOR #09(B)
The ability of States to determine the percent of adolescents in grades 9 through 12 who report using tobacco products in the past month. - Formerly Developmental Health Status Indicator #05

Ohio has been conducting the Youth Risk Behavior Survey (YRBS) since 1993; starting in 2003, the survey has been conducted by ODH, DFCHS. In addition, the ODH Division of Prevention administers the Youth Tobacco Survey (YTS). The data from these surveys on use of tobacco products by youth is used for needs assessments and to monitor tobacco use among youth.

#09(C) HEALTH SYSTEMS CAPACITY INDICATOR
The ability of States to determine the percent of children who are obese or overweight.

ODH has the ability to collect data on overweight status of certain subpopulations of children who are obese or overweight, and has established a new State Performance measure on percent of 3rd graders who are overweight or at risk for overweight. Data on weight status of low income children 0-5-year olds is collected from the WIC program and sent to CDC for the Pediatric Nutrition Surveillance System. Self-reported data on weight status of youth in high school are available from YRBS.

Program staff is implementing a population based sampling methodology to determine county specific baseline BMI data for third graders in Ohio and have been disseminating technical assistance information about BMI measurement, appropriate interpretation and best practices

Other Data Systems

Child Fatality Review
Ohio has a legislatively mandated child death review system that is partially funded through Title V. Recognizing the need to better understand why children die, the Ohio General Assembly passed Substitute House Bill Number 448 (HB 448) in July 2000 mandating Child Fatality Review (CFR) boards in each of Ohio's counties (or regions) to review the deaths of all children younger than 18 years of age. The ultimate purpose of the local review boards, as clearly described in the law, is to reduce the incidence of preventable child deaths.

Eight-seven of the of 88 CFR boards submitted annual reports for 2004 describing their CFR board activity and death reviews for children who died in 2002. The county reports are compiled into an Annual Report to the Governor..

Of a total of 1,368 deaths reported (75 percent of all child deaths reported by Ohio Vital Statistics for 2002), key findings were as follows:

Sixty-two percent of all reviews were deaths to infants under the age of 1 year.

Seventy percent of all reviews were natural deaths; 79 percent of all natural deaths were infants.

Black children and boys died at a disproportionately higher rate than white children and girls for several causes of death.

Motor vehicle deaths accounted for 11 percent of all reviews; 54 percent were 15 -- 17 years old and 82 percent were white and 63 percent were boys. Of the deaths that occurred in cars or trucks, 47 percent of the deaths were to the child driver.

Eight percent of all review conducted were reported as SIDS. Black children died from SIDS at a disproportionately higher rate than white children; 44 percent of all SIDS deaths were black, 60 percent of all SIDS deaths were to boys. Forty-seven percent of the SIDS victims were found in locations that are considered particularly unsafe, such as a bed other than a crib or on a couch. Only 26 percent were found in a crib.

Other Sleep-related Deaths accounted for an additional 48 deaths to infants less than 1 year old. Only 7 percent of these deaths occurred in cribs, while 71 percent occurred in locations considered unsafe, such as other types of beds and on couches. Bedsharing was the most frequently reported factor for Sleep-related Deaths. Seventy-seven percent occurred to infants who were sleeping with someone else at the time of death.

More than 150 recommendations were submitted by local CFR boards. More than 20 counties shared information about local prevention initiatives that have resulted from the CFR process.

Ohio Family Health Survey
In 1998, ODH initiated the Ohio Family Health Survey (OFHS) to address the department's data gaps. Approximately, 16,000 telephone interviews were conducted to gather data on risk factors, health status, unmet need, access to care, and health insurance status. ODH and ODJFS collaborated in the implementation of the second round of OFHS in 2004 ODJFS funded the project and ODH provided technical assistance. Approximately 40,000 interviews were conducted and the data are currently being analyzed. Current funding comes from Medicaid, state general revenue and other ODH funding sources.

88 County Profiles of the Statewide Analysis of Unmet Primary Care
The DFCHS Primary Care Section compiled the Statewide Assessment of Unmet Need (SAUN) to identify areas of the state with the greatest health care needs, disparities and workforce shortages. The analysis looks at health status indicators, the existence and utilization of primary care resources, and over-utilization of non-primary care resources recognized for their relationship to health care access. The resulting 88 county profiles (modeled on the FQHC Need for Assistance criteria) serve as a useful resource tool for communities seeking FQHC and other funding and are posted on the ODH web site.The SAUN will be expanded to include data for the following MCG BG Performance Measures:
SPM 02: Percent of low birth weight black births among all live black births
SPM 03: Increase the capacity of the State to assess social/emotional health needs of MCH populations and to promote early identification, prevention and intervention services
SPM 04: Degree to which MCH programs can incorporate and evaluate culturally appropriate activities and interventions
SPM 05: Percent of 3rd graders who are overweight
SPM 06: Increase the state's capacity to assess the contribution of safety net providers in meeting the need for primary care, mental health, and dental services

21 Critical Indicators of Adolescent Health
In collaboration with the DFCHS Bureau of Health Services Information and Operational Support (Research and Evaluation Section), the BCHSSD Adolescent Health Program developed a rep[ort entitled "The Health of Ohio's Adolescents, 21 Critical Indicators". This report, framed after the national adolescent health initiative, presents Ohio and national data on the 21 critical indicators that have been identified by the nation's adolescent health experts that critically impact the health of adolescents. Ohio has collected state and national data to produce a profile of Ohio's Adolescents. This report represents a subset of a more comprehensive assessment of Ohio adolescents which is shared with health professionals, policy makes and government/community leaders as they plan programs for adolescents. This report will be updated annually.

Oral Health Survey
In 2004-05, the Bureau of Oral Health Services (BOHS) conducted its second county-level oral health survey to make oral health status and access data available to local planners. In collaboration with CDC and the Association of State and Territorial Dental Directors, BOHS led the development of a model for conducting local surveys which is used to train interested communities in Ohio.

To monitor progress toward meeting the Title V oral health performance measures, BOHS instituted an annual survey of 25 sentinel schools that were found to be highly representative of the 336 Ohio elementary schools selected for the 1998-99 county-specific survey. The sentinel schools approach will be evaluated after the 2004-05 data have been analyzed.

Through the HRSA-funded State Oral Health Collaborative Systems (SOHCS) grant, BOHS is developing an oral health surveillance system to describe need at the community level. This assessment of need will be combined with an instrument that BOHS has developed to assess community readiness for taking action on oral health issues. The resulting matrix will serve to prioritize counties for BOHS technical assistance.

BMI Survey of Third Graders
A population based survey of BMI status of Ohio third graders is being conducted to determine county specific baseline BMI data for third graders in Ohio. The survey was done on that same sample of third graders used for the oral health survey described above.

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

The Ohio Department of Health has recently updated its Strategic Plan and Performance Goals. Please see the attached documents.

Ohio is addressing all the 18 National Performance Measures, and the following ten State Performance Measures:

1 -- (State 1): Increase statewide capacity to reduce unintended pregnancies among populations at high risk for poor birth outcomes
2 -- (State 2): Percent of low birth weight black births among all live black births
3 -- (State 3): Increase the capacity of the State to assess social/emotional health needs of MCH populations and to promote early identification, prevention and intervention services
4 -- (State 4): Degree to which MCH programs can incorporate and evaluate culturally appropriate activities and interventions
5 -- (State 5): Percent of 3rd graders who are overweight
6 -- (State 6): Increase the state's capacity to assess the contribution of safety net providers in meeting the need for primary care, mental health, and dental services
7 -- (State 7): Percentage of 3rd grade children with untreated caries
8 -- (State 8): Implement Ohio Connections for Children with Special Needs (OCCSN) Birth Defects Registry System
9 -- (State 9): Increase the proportion of children who receive age- and risk-appropriate screenings for lead, vision, hearing, and oral health
10 --(State 10): Integrate ODH Maternal and Child Health Information Systems

B. STATE PRIORITIES

B. STATE PRIORITIES

Summary of Needs Assessment
The Needs Assessment Team used information about the health status of the MCH population gathered as a result of the five-year needs assessment to generate a list of needs organized by the four levels of the pyramid.

Direct Health Care Services

1. Access for low-income women and adolescents to perinatal and family planning safety net services
2. Access for low-income children and adolescents to dental care (including dental sealants)
3. Adequate numbers and distribution of providers accepting Medicaid
4. Direct funding of payment for health care services for those portions not covered by other funding sources.
5. Special equipment for CSHCN
6. Home health care for CSHCN
7. Mental health services for the MCH population, including CSHCN
8. Medical homes for CSHCN
9. Community-based care for CSHCN

Enabling Services

1. Assistance in the enrollment process for available health insurance plans

2. Targeted outreach efforts to bring high-risk women into early prenatal care
3. Culturally appropriate services for the MCH population
4. Prenatal smoking cessation programs
5. Programs that employ community health workers to improve access to care through culturally competent care coordination
6. Effective community-based outreach and enrollment strategies to ensure that children receive needed health care services through Medicaid/SCHIP
7. Information for families of CSHCN about available services and resources
8. Assistance with navigating systems for families of CSHCN
9. Transportation and translation services
10. Programs to provide nutrition services for those who are overweight and obese

Population-Based Services

1. Public awareness about reproductive health and family planning services
2. Awareness among low-income women about the importance of early and continual prenatal care
3. Understanding among pregnant women of the harmful effects on the fetus from smoking and consuming alcohol during pregnancy
4. Public awareness about the following:
* Overweight children and healthy eating and exercise
* Health effects of childhood lead poisoning
* Importance of early professional vision care for children
* Importance of early oral heath care for children
* Importance of immunization schedule
* Postponement of teen sexual activity
* Proper use of safety devices to decrease motor vehicle deaths in children
* Navigation of the health care system
* Adolescent asset building models
* Risk factors for adolescent suicide
* Risk factors for new adolescent drivers
* Mental and behavioral health issues in the MCH population

Infrastructure Building Services

1. Information and training for providers on the following:
* Factors contributing to low and very low birth weight
* Culturally competent practices
* Identifying populations at risk for poor birth outcomes
* Identifying populations at risk for mental and behavioral health problems
* Pediatric overweight; adult obesity
* Oral health status, oral health resources, and access to dental care
* Blood lead screening policy
* Vision assessment
* Hearing assessment
* Screening and referral
* Immunization schedule
* Adolescent risk assessment inventories
* Adolescent skill building and decision making models
* Promotion of motor vehicle safety
* Healthy Start/SCHIP information
* Risk factors for adolescent suicide
* Suicide prevention initiatives
* CSHCN in school settings
2. Quality data and information for policy development and program planning on the following:
* Smoking and alcohol use among pregnant women
* Access to early prenatal care, including high-risk

* Adequacy of prenatal care
* Effective outreach strategies
* Education needs of prenatal providers
* Low and very low birth weight factors and trends
* Rates of breastfeeding
* Injury prevention
3.Information for legislators, policymakers, and MCH stakeholders on risk factors contributing to low birth weight and the effect of prenatal care on birth outcomes
4. Understanding among prenatal service providers of the barriers to care that pregnant women face.
5. Capacity building among local public health agencies to conduct a community health assessment and planning process including 88 county profiles of unmet primary care needs
6. A statewide system for infant, child, and adolescent death review
7. Quality data and information for policy development and program planning on the following:
* Childhood lead poisoning prevention
* Effective immunization outreach strategies
* Contributing factors for teen pregnancy and low birth weight
* Motor vehicle crashes
* Rate of uninsured children served through safety net health care programs
* Medicaid provider recruitment, training, and reimbursement
* Uninsured rates for children
* Medicaid eligible children receiving services
* Barriers to Medicaid enrollment
* Placement of primary care providers and board certified pediatric specialists in underserved areas
9. Coordination/collaboration with the state Medicaid program regarding enhanced blood lead screening for Medicaid eligible children
10. Collaboration among public and private agencies to coordinate immunization planning efforts
11. Information for legislators, policy makers, and MCH stakeholders regarding contributing factors related to teen birth rates
12. Coordination among complex government programs.
13. Access to providers (e.g., increasing the number of Medicaid providers and providers who accept uninsured patients using a sliding fee scale based on 200 percent FPL.
14. Continuity of care with the established provider for CSHCN
15. Establishment of a network of providers in both urban and rural areas who are needed to diagnose and treat asthma and pervasive developmental disorders
16. Availability of community PHN services
17. Comprehensive population-based data on CSHCN

B. Prioritization of Issues

As described in Ohio's needs assessment methodology, prioritization was accomplished in two phases:
I. Separately for (a) maternal and infant, (b) early childhood, (c) school-aged child and adolescent, and (c) CSHCN populations (B.1)
II. Unified for the entire MCH population (B.2)

B.1 Issues Ranked in Priority Order in Phase I Needs Assessment Workgroups

Women's Health, Birth Outcomes and Newborn Health Issues Ranking

1.Access to adequate prenatal care/health insurance
2.Preterm Births/LBW
3.Preconception/Family Planning/Unintended pregnancy/genetics referrals and services
4.Neonatal/Perinatal Mortality
5.STDs/HIV/Hepatitis
6.Overweight/Nutrition
7.Smoking

8.Interconceptional Care
9.Mental Health/Postpartum and Perinatal Depression

Early Childhood Health Issues Ranking
1.Health Coverage and Access to Care
2. Access to Comprehensive Services including: Immunizations, Oral Health, Vision, Hearing, Lead Screening, Behavioral and Mental Screening
3. Infant Mortality
4. Child Care and Development
5. Child Injury
6. Child Death
7. Overweight and Nutrition
8. Social/Emotional Health Issues
9. Environmental Issues
School-Aged Child and Adolescent Health Issues Ranking
1.Insurance/Health Care Access and Use
2.Chronic Disease Prevention
3.Screenings (Includes Oral Health, Vision, Hearing
4.Mental Health Issues
5.Sexual Behaviors
6.Substance Abuse Issues
7.Suicide
8.Motor Vehicle Issues

Children with Special Health Care Needs Health Issues Ranking

1. Insurance/Access/Payment Issues
2. Care Coordination: Medical Home/Community
3. Services for Congenital and Genetic Conditions
Transition
4. Access to specialty and specific health care services
5. Mental Health
6. Medical Condition and Services
7. Impact on Family

B.2. Top Ten MCH Health Issues Identified in the Phase II Process (Unranked)

* Improve birth outcomes
* Assure quality screening, identification, intervention, care coordination and medical home
* Assure access to comprehensive preventive and treatment services for individuals and families, including Children with Special Health Care Needs
* Promote age-appropriate nutrition and physical activity
* Improve oral health and access to dental care
* Enhance social/emotional strengths of families
* Increase collaboration and coordination of programs for families through partnerships and data integration
* Incorporate racial/ethnic/cultural health equity in all activities
* Decrease substance abuse and addiction, including tobacco
* Promote sexual responsibility and reproductive health

Data Analysis/Research Agenda

During the course of reviewing data as part of the needs assessment process, the Needs Assessment Team identified gaps in data and information that would have been helpful to better identify populations at risk and contributing factors toward which interventions could be developed. When

such gaps in data were identified, they were noted. They since have been incorporated as strategies in the FFY 2006 MCH Block Grant and thereby represent the continual process of needs assessment that will be undertaken by DFCHS in the coming year. Listed below are gaps in data that were identified through that process and will formulate our research agenda for FFY 2006.

NPM 03, Medical Home
Conduct analyses of the impact of the "Medical Home" on CSHCN using results of the National CSHCN Survey that is now in the field, as well as other National Child Health Surveys.

NPM 04, CSHCN with a Source of Insurance for Primary and Specialty Care
Use results from the Ohio Family Health Survey to describe CSHCN access to Medical Home and source of health insurance.

NPM 8, Motor Vehicle Death Rates (children ages 1 through 14)
Assess current literature and available data to identify at-risk populations, gaps in data, and opportunities for future programs.

NPM 11: Percent of mothers who breastfeed their infants at hospital discharge.
Identify data sources and methodologies to describe the proportion of Ohio mothers who exclusively breastfeed at hospital discharge and at 6 and 12 months.

NPM 15, Very Low Birth Weight Live Births
Assess current literature and available data to understand associations of Artificial Reproductive Technology with multiple births and VLBW trends.

NPM 17, Very Low Birth Weight Infants Delivered at Facilities for High-Risk Deliveries and Neonates
Analyze current information regarding newborn survival rates at Level II and Level III hospitals by the following: specific birth weights and gestation; provider criteria for transfer of high-risk pregnancies to Level III facilities (e.g., referrals, use of transport); availability of high-risk services; cost of transport and care; and the impact of insurance/provider referral on transport practices.

CPM 18, Infants Born to Pregnant Women Receiving Prenatal Care Beginning in the First Trimester
Analyze current information on the women who are not getting care (e.g., defining subpopulations, cultural practices, geographic areas, insurance practices) in order to develop more effective outreach strategies.

SPM 01, Increase statewide capacity to reduce unintended pregnancies among populations at high risk for poor birth outcomes
A. Identify characteristics of Ohio women experiencing unintended pregnancy and contributing factors (e.g., use of birth control).

B. Conduct programmatic research, literature reviews, and time-limited demonstration projects to identify evidence based practices that might be best for delaying first pregnancy among those under 18 years, and lengthening birth spacing among the high risk population in Ohio.

SPM 02, Percent of low birth weight black births among all live black births
Identify strategies to address subpopulations in the African American population at risk for poor birth outcomes.

SPM 04: Degree to which MCH programs can incorporate and evaluate culturally appropriate activities and interventions
Develop and implement a consumer survey to measure acceptability of health care in relation to cultural sensitivity.

SPM 06: Increase the state's capacity to assess the contribution of safety net providers in meeting the need for primary care, mental health, and dental services.

A.Conduct programmatic research, literature reviews and consumer surveys to develop definitions of access to various treatment and preventive services and ways to measure.

B.In regard to access to care, evaluate the degree to which Ohio is doing the right things(per analysis of root causes of poor access); then if Ohio is doing the right things, evaluate the degree to which they are being done right).

SPM 08: Implement Ohio Connections for Children with Special Needs (OCCSN) Birth Defects Registry System
Evaluate the success and effectiveness of the OCCSN Birth Defects Registry System to 1) collect and link birth defects data with other child records; 2) implement a parent notification and referral system; and describe the degree to which coordination between HMG and other CSHCN programs occurs.

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			100	100	100
Annual Indicator		99.3	100.0	97.3	
Numerator		134	128	144	
Denominator		135	128	148	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100

Notes - 2002

Data source: ODH Laboratory data for 2001 cases. Calendar year data. Numerator is the number of infants screened for all conditions, needed treatment and received treatment.

Notes - 2003

Data source: ODH Laboratory data for 2003 cases. Calendar year data. Numerator is the number of infants who received follow-up. Denominators are those screened and confirmed.

Notes - 2004

2004 data not available.

a. Last Year's Accomplishments

The target for Calendar Year 2003 was 100 percent. The actual percent of newborns who were screened and confirmed with conditions mandated by the state and who receive appropriate follow-up was 97.3 percent. Ohio did not meet its goal.

A. Attend and participate in Newborn Screening Advisory Council meetings.
* ODH Genetics Section staff and representatives from Regional Comprehensive Genetic Centers and Sickle Cell Projects participated and attended 3 Newborn Screening Advisory Council meetings.
* ODH Sickle Cell Program staff convened 3 meetings of local sickle cell newborn screening coordinators.
* ODH Genetics Section staff met 5 times with ODH Newborn Screening Lab staff.

B. Evaluate operations of current metabolic formula program and make recommendations for program revision to be less ODH labor intensive and more cost efficient.
* ODH met with Metabolic Dietitians 6/29/04 to discuss program efficiency strategies.
* Strategies presented and approved by Division Chief in 08/2004.
* ODH moving forward to implement strategies in FFY05.
* Ohio's Newborn Screening Fee increase to go into effect 12/13/2004.

C. Participate in the development and implementation of Ohio's Integrated Perinatal Public Health Information System (IPPHIS), a common data portal for newborn and birth information.
* ODH Genetics Section staff actively participated in the development of the IPPHIS specifications for an RFP to be announced in Dec. 2004.

D. Collaborate with ODH Vital Statistics staff to train birthing hospitals to collect the newborn screening kit number via the Electronic Birth Certificate screening information.
* Since 07/01/04, 30,529 birth certificates (79 percent) have the newborn screening kit number recorded.
* ODH Vital Statistics did not provide any additional training to hospitals during FFY04.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participated in Newborn Screening Advisory Council meetings.				X
2. Evaluated operations of current metabolic formula program and made recommendations for program revision.				X
3. Participated in development and implementation of Ohio's Perinatal Public Health Information System, a common portal for newborn and birth information.				X
4. Collaborated with ODH Vital Statistics staff to train birthing hospitals to collect the newborn screening kit number via the Electronic Birth Certificate screening information.				X
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities

A. Convene work group of staff from Division of Family, Regional Comprehensive Genetics Centers, Regional Sickle Cell Services Projects and ODH Lab to draft definition of newborn screening follow-up for Ohio, including indicator(s) for measuring newborn screening follow-up for evaluation and reporting, and submit to the Newborn Screening Advisory Council for approval.

B. Review and evaluate Metabolic Formula Program operations and submit option(s) for program revision to ODH administration for determination of future program direction.

C. Collect baseline data on the reporting practices of primary care providers regarding newborn screening, i.e., their responsibility per Ohio Administrative Code to follow up on abnormal screening results of their patients.

D. Monitor progress of hospitals reporting of newborn screening kit number on electronic birth certificate (EBC).

c. Plan for the Coming Year

A. Plan for the integration of NBS Laboratory confirmatory diagnoses data with service provision data through Ohio's birth defects information system.

B. Develop a baseline of the percentage of primary care providers who are in compliance with Ohio's administrative rules for the timeliness of newborn screening case disposition reporting.

C. Develop newborn screening manuals for follow-up protocols for genetics and sickle cell programs to improve uniformity, consistency and reporting.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			60	60	60
Annual Indicator			59.3	59.3	59.3
Numerator					
Denominator					
Is the Data					

Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	75	75	75	75	75

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

The target for Calendar Year 2004 was 60 percent. The actual percent of CSHCN whose families partner in decision making at all levels and are satisfied with the services they receive was 59.3 percent. According to the Children with Special Health Care Needs Survey (SLAITS), Ohio has not met its target.

A. Develop and implement a plan to increase cultural diversity, family involvement, and financial support for parent activities and family member participation on more DFCHS advisory committees and task forces.

Parents of children with special health care needs have been offered seats on advisory committees. These parents receive stipends to cover child care expenses and receive reimbursement for other travel related costs if requested.

B. Develop and begin to implement a system of transition to adult health care as youth with special needs age out of the pediatric system.

Held intial meetings with practitioners interested in starting pilot transitions projects in the Dayton and Cincinnati area childrens hospitals.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. To increase cultural diversity and parent involvement, parents of CSHCN were offered seats on advisory committees and were offered reimbursement for travel and child care expenses.			**X**	
2. Held meetings with practitioners interested in starting pilot transition projects in Dayton and Cincinnati area children's hospitals.				**X**
3.				
4.				
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities

A. Increase financial and informational support for parents to participate in meetings of PAC, BCMH committees, DFCHS committees.

B. Develop more methods of getting information to parents, over and above the Newsletters.

C. Develop method to evaluate BCMH/BEIS joint venture in which PHNs are HMG service coordinators, relying heavily on family satisfaction.

c. Plan for the Coming Year

A. Evaluate family satisfaction portion of the BCMH/BEIS Pilot.

B. Work with HMG regarding FIN focus groups data to evaluate family satisfaction and program impact on families for 0-3 population.

C. Develop, pilot and distribute handbook on navigating healthcare systems for parents of CSHCN.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective			55	55	56
Annual Indicator			55.9	55.9	55.9
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	60	60	60	60	60

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

The target for Calendar Year 2004 was 55 percent. The actual percent of CSHCN who received coordinated, ongoing, comprehensive care within a medical home was 55.9 percent. According to the Children with Special Health Care Needs Survey (SLAITS), Ohio has met its target.

A. The BCMH hired a college intern and with the assistance of BHSIOS and the FACCT web site analyzed the national CSHCN survey and developed a report comparing the Ohio data to the national data.

B. The Ohio Medical Home Workgroup met on a regular basis and coordinated the Ohio Medical Home projects implementing the "Promise to the State".

C. BCMH distributed medical home educational materials to parents of CSHCN and providers of care to CSHCN through the parent newsletters and other communications.

D. BCMH continued to support its two Medical Home Pilot sites.

E. BCMH developed and distributed a Parent Medical Home Brochure.

F. BCMH collaborated with Dr. Ron Levine and Cincinnati Children's Hospital on development and support of a CSHCN resources web site.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. BCMH hired a college intern and with the assistance of BHSIOS and the FACCT web site analyzed the national CSHNC survey and developed a report comparing the Ohio data to the national data.				X
2. The Ohio Medical Home Workgroup met on a regular basis and coordinated the Ohio Medical Home projects implementing the "Promise to the State".				X
3. BCMH distributed medical home educational materials to parents of CSHCN and providers of care to CSHCN through the parent newsletters and other communications.			X	
4. BCMH continued to support its two Medical Home Pilot sites.				X
5. BCMH developed and distributed a Parent Medical Home Brochure.			X	
6. BCMH collaborated with Dr. Ron Levine and Cincinnati Children's Hospital on development and support of a CSHCN resource web site.				X
7.				
8.				
9.				

10.				

b. Current Activities

A. Investigate feasibility of expanding Medical Home Pilots within Medical Home Learning Collaborative model to 3 new practices.

B. Perform in-depth analysis of CSHCN (SLAITS) survey for baseline measurement of the Medical Home. Contract with a university for biostatistics contract.

C. Distribution of speakers' educational package on Medical Home with input from the AAP joint committee on Children with Disabilities so that other programs who serve the CSHCN population seen in specialty clinic, BCFHS, Medicaid, BEIS, etc. teams can inform their providers and clients.

D. Use Cooley survey tool to develop satisfaction measures relative to medical home with the Medical Home Learning Collaborative pilot families and compare to non-pilot CSHCN families.

c. Plan for the Coming Year

A. Develop and implement a Medical Home service coordinator for CSHCN in managed care in collaboration with ODJFS, Bureau of Managed Care.

B. Implement physician CEU program on web regarding CSHCN Medical Home

C. Continue to support Cincinnati Children's Hospital Resource Directory (web-based) Grant activities (TBD)

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective			60	60	75
Annual Indicator			60.8	60.8	60.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance	75	75	75	75	75

Objective					

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

The target for Calendar Year 2004 was 60 percent. The actual percent of CSHCN whose families have adequate private and/or public insurance to pay for the services they need was 60.8 percent. According to the Children with Special Health Care Needs Survey (SLAITS), Ohio has met its target.

A. Monitor data on enrollment of uninsured BCMH treatment recipients on Healthy Start (SCHIP) and analyze reasons for not being enrolled.

This activity was deferred until a later time.

B. Pay health insurance premiums and Medicaid spend down amounts for CSHCN when cost effective, in comparison with direct payment of treatment services.

BCMH paid health insurance premiums and spend down when cost effective.

C. Provide enrollment assistance for potentially eligible Healthy Start SCHIP children.

Field staff worked with local public health nurses to provide technical expertise for families eligible for Healthy Start.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Paid health insurance premiums and Medicaid spend down for CSHCN when cost effective.		X		
2. BCMH field staff worked with local public health nurses to provide technical expertise for families eligible for Healthy Start.		X		
3. BEIS and BFCHS worked very cosely on outreach and identification of children with special health needs, especially in a 7-county pilot.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A. Monitor data on enrollment of uninsured BCMH treatment recipients on Healthy Start (SCHIP) and analyze reasons for not being enrolled.

B. Pay health insurance premiums and Medicaid spend down amounts for CSHCN when cost effective, in comparison with direct payment of treatment services.

C. Provide enrollment assistance for potentially eligible Healthy Start (SCHIP) children through collaboration with local public health nurses and Team Service Coordinators located at the Children's Hospitals.

D. Ensure collaboration between BCMH, BCFHS, and BEIS for outreach to uninsured children identified through BCFHS Specialty Clinics, the BCMH Diagnostic clinics, and BEIS Programs.

c. Plan for the Coming Year

A. Meet with Ohio Department of Insurance on possible inclusion of CSHCN in a high-risk insurance pool.

B. Hold 6 regional education meetings on "full utilization of insurance benefits" including local public health nurses, HMG service coordinators for families of CSHCN.

C. Acquire and distribute to families of CSHCN the Ohio Coalition for Education of Children with Disabilities booklet "A Formula" as a guide for accessing insurance and medical care as well as other pertinent materials.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			80	80	81
Annual Indicator			80.2	80.2	80.2
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	90	90	90	90

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

The target for Calendar Year 2004 was 80 percent. The actual percent of youth who received the services necessary to make transition to all aspects of adult life was 80.2 percent. According to the Children with Special Health Care Needs Survey (SLAITS), Ohio has met its target.

A. BCMH through its Public Awareness contracts with 102 local public health departments nurse provided information to families related to the availability of local services and resources utilizing direct contact, print media, radio and television announcements.

B. BCMH continued financial support for the Public Awarenss contracts with the informational outreach being a main requirements for the contract vendors (local public health departments).

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. BCMH through its Public Awaremess contracts with 102 local public health department nurses provided information to families related to the availability of local services and resources utilizing direct contact, print media, radio and television announ			X	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A. Conduct educational activities with local public health nurses, hospital based service coordination related to public awareness activities for informing families of community based services.

B. Follow upon specific recommendations from parent focus groups to assist policy makers in funding for specific community-based services.

c. Plan for the Coming Year

A. Conduct 6 regional education meetings on "the many aspects of Medicaid" including ODJFS, HMG for families of CSHCN.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			10	10	10
Annual Indicator			5.8	5.8	5.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	25	25	25	25	25

Notes - 2002

Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its State value noted.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

The target for Calendar Year 2004 was 10 percent. The actual percent of youth who received the services necessary to make transition to all aspects of adult life was 5.8 percent. According to the Children with Special Health Care Needs Survey (SLAITS), Ohio did not meet its target.

A. Collaborated with CSHCN stakeholders to assess transition activities for adolescent from pediatric to adult oriented healthcare. BCMH held meetings with hospital based team service coordinator to discuss transition activities and ways to strengthen successful transition outcomes.

B. BCMH continued to hold meetings with service coordinators in the Dayton and Cincinnati area to lay foundation for transition activities.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. BCMH held meetings with hospital-based team service coordinators in the Dayton and Cincinnatii areas to lay foundation for transition activities.				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A. In state fiscal year 05 the ODH sickle cell program is requiring each of its grantees to address a transition performance indicator that estimates the number of adolescents that have a written transition plan in place which addresses needed services, provider of services, and how services will be financed.

B. Conduct 3 adolescent focus groups related to transition.

C. Collaborate with Cincinnati Children's Hospital to develop an adult transition service coordination component for adolescent clients with cerebral palsy and myelomeningocele served by the hospital based clinics.

c. Plan for the Coming Year

A. Review transition focus group report and develop recommendations.

B. Conduct quarterly, regional meetings with the Young Adult Advisory Council.

C. Invite pertinent agencies/staff to present at YAAC Council meetings, i.e. Rehab Service Commission, SSI, Genetics Counselors.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					
Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**

Annual Performance Objective	85	85	75	79	79
Annual Indicator	68.9	71.2	75.0	82.3	82.3
Numerator	148458	162044	173818	188056	188056
Denominator	215469	227590	231758	228501	228501
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	84	84.5	85	85.5	86

Notes - 2002

Numerator: Data source: Estimated percent of Ohio children 19-35 months of age with vaccination coverage (series 4:3:1:3:3 = 4 doses DTaP or DTP, 3 doses polio, 1 dose MMR, and 3 doses Hib.) from the U.S. National Immunization Survey, (MMWR August 03, 2001 / 50 (30). Percent value is + or - 5.

Ohio revised 1998 and 1999 data using denominators generated with census data as in 2000 and 2001. The numerators were generated by applying Ohio's CDC percentage of vaccination coverage to the denominators. These revisions will make it possible to examine trends of coverage and were implemented in compliance with Federal guidance and instructions.

Notes - 2003

Numerator: Data source: Estimated percent of Ohio children 19-35 months of age with vaccination coverage (series 4:3:1:3:3 = 4 doses DTaP or DTP, 3 doses polio, 1 dose MMR, and 3 doses Hib.) from the U.S. National Immunization Survey, (MMWR Q3/2003 - Q2/2004. Percent value is + or - 5.

Data for the denominator from the U.S. census bureau. The numerator was generated by applying Ohio's CDC percentage of vaccination coverage to the denominators.

Notes - 2004

Data for 2004 is not yet available. 2004 data is an estimate.

a. Last Year's Accomplishments

The target for Calendar Year 2003 for the 4:3:1:3:3 series was 79 percent. The actual percent of 19 to 35 months olds who received the full schedule of appropriate immunizations for age was 82.3 Ohio has met its target and has adjusted its target for the coming years accordingly.Note: The data source for this measure, the National Immunization Survey, did not have a large enough sample size to report by race for Ohio.

A. Forty of the 79 Child and Family Health Service (CFHS) programs received a visit from their program consultant in 2004. Match data was used when evaluating immunization data prior to the visits. The Match data was then shared and discussed with program staff.

B. Seventy percent of the CFHS projects utilize the statewide immunization registry. The Division of Prevention continues to work with BCFHS bureau to encourage all Division of Family and Community Health Services (DFCHS) funded programs to access and utilize the statewide immunization registry.

C. Forty five percent of the 79 counties with CFHS funded clinics have chosen an immunization

focused performance measure as a strategy for state fiscal year 2004. Help Me Grow addressed immunization status with HMG families by adding an immunization status question to the Individualized Family Service Plan. Literature is distributed at various health fairs and immunization and well child clinics. Trainings continue with providers and their professional staff to communicate latest information on childhood immunizations per Maximizing Office Based Immunization (MOBI) presentations.

D. WIC local clinics continue to gather immunization information from the clients they serve. Clients with an incomplete immunization status are immunized at a clinic in their building or referred to an immunization clinic that services the un and underinsured. BCFHS continues to be represented on the Ohio Immunization Advisory Group. This committee fosters collaboration with the Ohio Department of Jobs and Family Services, American Academy of Pediatrics- Ohio Chapter, local counties and others, to increase the immunization rate across the state.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Evaluated immunization levels of children enrolled in 40 of 70 CFHS well child programs.				X
2. Collaborated with the ODH Division of Prevention to encourage all DFCHS funded pograms to utilize the statewide immunization registry.				X
3. CFHS and WIC clinics provided immunizations and/or promoted the importance of immunizations.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A. Monitor immunization data from DCFHS funded programs including CFHS, BCMH, Primary Care clinics and WIC.

B. Promote the use of the statewide immunization registry by DFCHS funded programs.

C. Promote compliance, within DCFHS funded programs, of the immunization schedule according to the MCHBG series.

D. Collaborate and coordinate immunization planning and programming efforts with national, state, and local health programs.

c. Plan for the Coming Year

A. Monitor immunization data from DCFHS funded programs including CFHS, BCMH, Primary Care clinics and WIC.

B. Promote the use of the statewide immunization registry by DFCHS funded programs.

C. Promote compliance, within DCFHS funded programs, of the immunization schedule according to the MCHBG series.

D. Collaborate and coordinate immunization planning and programming efforts with national, state, and local health programs.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	26.9	23.5	21.5	18	18
Annual Indicator	24.3	22.0	19.9	20.0	
Numerator	5797	5251	4779	4756	
Denominator	238527	238527	240139	237328	
Is the Data Provisional or Final?				Provisional	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	18	18	18	18	18

Notes - 2002

Data for denominator from US Census Bureau, population estimates.

Notes - 2003

Data for denominator from US Census Bureau, population estimates. 2003 Teen birth data is preliminary.

Notes - 2004

Data for 2004 is not available.

a. Last Year's Accomplishments

The target for Calendar Year 2003 was 18.0 births per 1,000 live births to teens age 15-17. Ohio's actual rate was 20.0. Based on provisional Vital Statistics data, Ohio did not meet its target.

A. The Family Planning Program began to discuss how to develop a resource mapping process that would identify counties with increased pregnancy rates and then develop a methodology to match the greatest county needs with resources.

B. The Family Planning Program identifed types of prevention programs targeted to adolescents and shared the information with partners. A survey was not done, but a Best Practices document was completed and shared with local Child and Family Health Services projects.

C. A workgroup composed of stakeholders interested in adolscent and school health met to discuss information related to adolescent health for the block grant needs assessment process. Information regarding programming resources from respective ODH program areas was shared.

D. Policy makers, community leaders, local programs, and agencies were provided information regarding the availability of grant funds for women's health and family planning programs.

E. DFCHS staff collaborated with local agencies to encourage teen sexual postponement. The Family Planning Program collaborated with adolescent health, school nurses and the CDC Infertility Prevention Program to analyze and share data concerning services to adolescents.

F. The Family Planning program funded and monitored 66 family planning sites. Nine subgrantees received comprehensive site reviews that covered clinical, administrative, fiscal and outreach components.

G. The Family Plannning program began the process to identify hard to reach teen populations. The information will be communicated to funded projects in the next grant period.

H. DFCHS collaborated with the Abstinence-Only program to share resources. The Abstinence-Only program staff were invited to attend the MCHBG Birth Outcomes group. The BCFHS staff attended the statewide abstinence-only conference.

I. Data Fact Sheets that contain county information on birthrates and STD's were developed and will be shared with partners in the next grant period. Data fact sheets on unintended pregnancies were completed from PRAMS data and shared with partners. Index on birthrates, STD's, women in need, poverty and African-American females has been completed and will be included in the current Family Planning Program Request for Proposals.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Family Planning Program identified prevention programs targeted to adolescents and shared best practices with partners.				X
2. DFCHS staff collaborated with local agencies to encourage teen sexual postponement			X	
3. Family Planning Program funded and monitoreds 66 family planning sites.				X
4. Family Planning Program began the process to identify hard to reach teen populations.				X
5. DFCHS collaborated with the Abstinence-Only program to share resources.				X
6. Data Fact Sheets that contain county information on birth rates and STDs were developed; data fact sheet on unintended pregnancy was developed, using PRAMS data.				X
7.				
8.				
9.				

10.					

b. Current Activities

A. Conduct resource mapping process to identify counties with increased pregnancy rates.

B. Identify types of prevention programs targeted to adolescents.

C. Convene an internal ODH work group to share adolescent programming resources in their respective service areas.

D. Collaborate with DFCHS funded agencies, The Office of Abstinence Education, and other public health agencies to share resources and materials and to promote training opportunities to encourage teen sexual activity postponement.

E. Fund, evaluate and provide technical assistance to family planning projects that provide services to adolescents to improve preconception, inter-conception periods, and identify risk reduction activities that can reduce births to 15-17 girls.

F. Identify characteristics of teens with poor outcomes in the counties with increased pregnancy rates.

G. Compile Data Fact Sheets on state-level birthrates and state/county level STD's and share with partners.

c. Plan for the Coming Year

A. Identify baseline rates of pregnancy for teens aged 15-17 whose birth rate is over 17/1,000.

B. Identify populations and areas at risk for teen pregnancies.

C. Identify and apply appropriate evidence-based practices.

4. Apply appropriate evidence-based practices to target populations.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	50	36	38	40	42
Annual Indicator	36.0	34.0	39.9	39.9	
Numerator	447	422	503	503	

Denominator	1241	1240	1262	1262	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	44	44	44	44	44

Notes - 2002

Source: These data are drawn from an annual survey of 25 sentinel schools providing a population based estimate for the state.

Notes - 2003

Data drawn from an annual survey of 25 sentinel schools providing a population based estimate for the state.

Notes - 2004

Data for 2004 is not yet available.

a. Last Year's Accomplishments

The target for calendar year 2003 was 40 percent. The actual percent of third grade children who received sealants was 39.9. Ohio has nearly met the target.

A. Expand currently funded school-based and school-linked dental sealant programs to reach additional high- risk children in Ohio.

1. Technical assistance was provided to existing dental sealant programs regarding expansion into qualified contiguous areas, to a new fiscal agent for a previously existing program, and to smaller programs which ODH would like to merge to increase cost efficiency.

2. A meeting was held in March 2004 for all Ohio dental sealant programs (ODH-funded [18] and locally funded [3]) with an emphasis on sealant application materials and technique.

3. Technical assistance was provided to two sealant programs that are initiating Medicaid billing for dental sealants. A representative from the state Medicaid program met with sealant program staff at the March 2004 meeting to discuss problems they were experience with billing Medicaid for dental sealants.

B. Continue to fund, monitor and provide consultation and technical assistance to currently funded local agencies operating school-based dental sealant programs.

1. Eighteen school-based dental sealant programs were funded, serving 26,161 students in 37 counties.

2. Program performance was monitored via quarterly program and expenditure reports.

3. Technical assistance was provided to programs via phone calls, email and the meeting with sealant programs held in March 2004.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Expanded currently funded school-based and school-linked dental sealant programs to reach additional high-risk children.				**X**
2. Trained dental sealant programs on sealant application materials and technique.				**X**
3. Funded, monitored and provided consultation and technical assistance to currently funded local agencies operating school-based dental sealant programs.				**X**
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A. Expand currently funded school-based and school-linked dental sealant programs to reach additional high-risk children in Ohio.

B. Continue to fund, monitor and provide consultation and technical assistance to currently funded local agencies operating school-based dental sealant programs.

c. Plan for the Coming Year

A. Expand currently funded school-based and school-linked dental sealant programs to reach additional high-risk children in Ohio.

B. Continue to fund, monitor and provide consultation and technical assistance to currently funded local agencies operating school-based dental sealant programs.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	3	2.8	2.5	2.5	2.4
Annual Indicator	3.9	2.8	3.2	3.3	
Numerator	88	66	77	77	
Denominator	2250619	2399087	2387154	2327236	
Is the Data					

Provisional or Final?				Provisional	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	2.4	2.4	2.4	2.4	2.4

Notes - 2002

Numerator: Vital statistics death records from 2001 (beginning with 1999 are coded using ICD-10)
Denominator [Census 2000]: from U.S. Census Bureau
Infants < 1 year are excluded from numerator and denominator for 1999 and 2000

Notes - 2003

Numerator: Vital statistics death records from 2002 (beginning with 1999 are coded using ICD-10)
Denominator [Census 2000]: from U.S. Census Bureau
Infants < 1 year are excluded from numerator and denominator for 1999 and 2000

Death data for 2003 is preliminary.

Notes - 2004

Data for 2004 is available.

a. Last Year's Accomplishments

The target for Calendar Year 2003 was 2.5 deaths per 100,000 children. Ohio's actual rate was 3.3. Based on provisional Vital Statistics data, Ohio did not meet its target

A. The rate of deaths and contributing factors of motor vehicle crash fatalities for children have been monitored and analyzed via child fatality review data. Ohio Child Fatality Review identified 153 child deaths from motor vehicle crashes in 2002. Forty-five percent of the deaths were to children 14 years and younger. Driver error was cited in 46 percent of the deaths; alcohol and/or drug impairment was cited in 17 percent. Restraints were not used in 43 percent of the deaths.

B. Ohio Child Fatality Review data was collected, analyzed, and organized into an annual report that was submitted to the Governor and legislative leaders. The report was shared with other state agencies and child health partners at the CFR Advisory Committee meeting and at other meetings within ODH.

C. Local CFR boards have been encouraged to share their findings with their communities. Several reported this process has resulted in local prevention initiatives targeting specific populations of teen drivers.

D. A Motor Vehicle Death supgroup with members from ODH, Public Safety, Law enforcement, coroners group, and other child health advocate groups met to share information and develop prevention strategies. The CFR Advisory Committee sent a letter to the director, urging support for legislation to strengthen the graduated licensing laws.

E. Materials for education on the proper use of safety devices was provided through the Newborn Home Visiting program in Help Me Grow, through the Child and Family Health Services clinics in MCH, and through various programs in Injury Prevention.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitored and analyzed MV death rates and contributing factors via Vital Statistics and Child Fatality Review data.				X
2. Prepared Annual Child Fatality Review Report for governor and legislators.				X
3. Encourage local CFR boards to share findings with communities and develop prevention strategies.			X	
4. Convened Motor Vehicle Death subgroup with members from ODH, Public Safety, law enforcement, coroners group and others to share information and prevention strategies.			X	
5. Provided materials for education on proper use of safety devices to parents through Newborn Home Visiting program in HMG, through CFHS clinics and through various programs in Injury Prevention.			X	
6.				
7. .				
8.				
9.				
10.				

b. Current Activities

A. Monitor the rate of deaths and analyze the contributing factors of motor vehicle crash fatalities for children.

B. Examine state Child Fatality Review (CFR) data and share the results with ODH programs, other state agencies and local child health partners.

C. Encourage local CFR boards to share motor vehicle data with local agencies who provide services for children.

D. Collaborate with injury programs within ODH and other state agencies to develop strategies to decrease motor vehicle injuries and deaths among children, including the proper use of safety devices.

c. Plan for the Coming Year

A. Use Vital Statistics data to monitor the rate of deaths per 100,000 to children aged 14 years and younger caused by motor vehicle crashes; use Child Fatality Review data to monitor the percentage of deaths among all deaths reviewed caused by motor vehicle crashes.

B. Using state child Fatality Review data, analyze the factors that contribute to deaths among children aged 14 years and younger caused by caused by motor vehicle crashes. Share the information with ODH programs, other state agencies and local child health partners.

C. Encourage local Child Fatality Review Boards to share information and recommendations about prevention of motor vehicle deaths among children aged 14 years and younger with local partners who can reach families and children, such as the local media, Help Me Grow, county Family and Children First, Ohio Buckles Buckeyes, and service agencies such as Kiwanis Clubs.

D. Collaborate with injury programs within ODH and other state agencies such as the Ohio Department of Public Safety, to develop strategies to decrease motor vehicle injuries and deaths among children, including the proper use of safety devices.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	53	61	65	65	65
Annual Indicator	61.0	62.4	63.7	61.6	
Numerator	94990	94311	94169	92294	
Denominator	155721	151140	147832	149828	
Is the Data Provisional or Final?				Provisional	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	66	66	67	67	67

Notes - 2002

Numerator: imputed from applying 62.4 percent of mothers breastfeeding at hospital discharge reported from the 2001 "Mothers' Survey" Ross Products Division, Abbott Laboratories, Inc., to the number of 2000 occurrent births.
Denominator: Ohio occurrent births 2001.

Notes - 2003

Numerator: imputed from applying 61.6 percent of mothers breastfeeding at hospital discharge reported from the 2003 "Mothers' Survey" Ross Products Division, Abbott Laboratories, Inc., to the number of 2003 occurrent births.
Denominator: Ohio occurrent births 2003.

Note: Total births do not include residents who gave birth out of state. 2003 birth data is preliminary.

Notes - 2004

Data for 2002 is not yet available.

a. Last Year's Accomplishments

The target for calendar year 2003 was 65 percent. The actual percent of Ohio mothers who breastfed their infants at hospital discharge was 61.7, a decrease from the previous two years. Based on provisional vital statistics data, Ohio did not meet its target.

A. ODH used WIC data (PedNSS), PRAMS data and the Ross Mother's Survey to monitor

breastfeeding rates. A committee met to review and discuss the data on a quarterly basis. The breastfeeding rate at hospital discharge has steadily climbed to where it currently stands at nearly 64 percent.

B. Back to Basics breastfeeding training was conducted once with over 150 participants from WIC, OIMRI and CFHS. The WIC symposium hosted a two-day breastfeeding component serving over 80 participants. Four public health nurse statewide orientation trainings were provided with breastfeeding as a component on two of the eight days. The breastfeeding committee updated and distributed the infant feeding policy to all BCFHS projects, and provided technical assistance to over 60 sites.

C. ODH worked with local, state and national maternal and child health stakeholders to promote breastfeeding. The breastfeeding committee includes maternal and child health stakeholders in the quarterly meetings. Committee members attend other consortia meetings and events across the state including Ohio Certified Lactation Consultants, March of Dimes, and strategy workgroups within county collaboratives.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Analyzed WIC, PRAMS and Ross Mothers' Survey data to monitor breastfeeding rates.				X
2. Conducted Back to Basics breastfeeding training for over 150 WIC, OIMRI and CFHS staff; hosted two-day training at state WIC seminar				X
3. ODH Breastfeeding Committee worked with local, state and national maternal and child health stakeholders to promote breastfeeding.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A. Participate in the ODH Breastfeeding Committee. (BCFHS, BNS, BEIS, BCMH, BSHIOS, BOHS)

B. Assess what is currently being done to promote Breastfeeding in Ohio through the ODH Breastfeeding Committee. (BCFHS, BNS, BEIS, BCMH)

C. Observe World Breastfeeding Week through a display in the ODH lobby. (BNS)

D. Provide information to CFHS projects regarding "Back to Basics" training and encourage attendance. (BCFHS)

E. Fund 6 RPEC projects to promote breastfeeding throughout their perinatal regions. (BCFHS)

F. Support and encourage hospitals to achieve baby friendly certification.

G. Support and encourage mother friendly workplace policies.

c. Plan for the Coming Year

A. Assess what is currently being done to promote breastfeeding among DFCHS funded projects.

B. Develop a brief monograph on Mothers' Infant Feeding Attitudes and Practices, using PRAMS and other survey data.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	8	8	8	30	30
Annual Indicator	8.0	17.5	22.1	39.4	39.4
Numerator	12457	26471	32668	58976	58976
Denominator	155721	151140	147832	149828	149828
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	50	75	85	90	92

Notes - 2002

Numerator: was derived from the universal newborn screening hearing conducted by over 35 hospitals in Ohio. These hospitals submitted hearing assessment forms for the babies they tested. Data are for pass and fail for babies in calendar year 2001.

Universal newborn hearing screening started late 2002, to be fully implemented by 2003-04. Targets reflect this change of program.

Notes - 2003

Numerator: was derived from the information voluntarily submitted by hospitals that are conducting Universal Newborn Hearing Screening which began in Ohio in 2003, but was not fully implemented until 7/1/04.

Note: Total births do not inlude residents who gave birth out of state.

Notes - 2004

Data is not available at this time. 2004 data is an estimate.

a. Last Year's Accomplishments

The target for calendar year 2003 was 30 percent. The actual percent of newborns who have been screened for hearing before hospital discharge was 39.4 percent. Ohio exceeded the target set for 2003 and has adjusted the targets for future years accordingly.

A. Problems arose with transferring data from the Electronic Birth Certificate into the Early Track (ET) data system for collecting and tracking results of universal newborn hearing screening (UNHS). Therefore, UNHS results were manually entered into ET. The birthing hospitals mailed result reporting forms to the Ohio Department of Health (ODH), beginning in January 2004, within 14 days of the screenings. The demographic information and screening results were entered into ET for infants who did not pass UNHS. The Regional Infant Hearing Program (RIHP) staff access ET and follow-up with families within two days urging them to schedule diagnostic audiologic evaluations to follow up on the non-pass UNHS results.

B. The Infant Hearing Program staff reviewed the UNHS protocols submitted by the 124 birthing hospitals for completeness and compliance with the law (HB 150). They provided technical assistance on the protocols and responded to questions from hospital personnel about UNHS implementation by phone and e-mail.

C. The Ohio Chapter Champion for the American Academy of Pediatrics (AAP), Dr. Susan Wiley, prepared a Grand Rounds presentation that she presented at Cincinnati Children's Hospital Medical Center and Dr. John Duby, current Ohio Chapter AAP president, presented at Children's Hospital Medical Center of Akron. ODH developed Medical Home Strategies for UNHS, for use by physicians in office and clinic settings. This well check chart follows AAP recommendations for screening/evaluation of hearing and outlines a plan of action and the rationale for each well child visit. The (RIHP) staff distributed the chart throughout the year.

D. The Infant Hearing Sub Committee of the BCMH Medical Advisory Committee met on these dates: 11/21/03, 2/27/04, 5/21/04, and 8/20/04. The members received updates on activities and provided guidance to the Infant Hearing Program staff on newborn hearing screening issues.

E. This was a continuation year for the nine RIHP sub grantees. The Infant Hearing Program staff made site visits to all RIHPs during the year. The Program Reports submitted by each RIHP were reviewed to evaluate the programs' abilities to conduct follow-up and tracking of newborn hearing screening referrals as well as to provide habilitative services to infants and toddlers with hearing loss.

F. The Infant Hearing Subcommittee discussed a genetics component as a standard of care for children with hearing impairments. A partnership with Ohio's Birth Defects Surveillance System has started.

G. An eleven-minute video, The Sounds of Life," was produced and distributed to all birth hospitals in Ohio.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Entered data from hospitals into Early Track data system and referred infants for follow up.				X
2. Infant Hearing Program staff trained birthing hospital staff on UNHS				X

protocols.				
3. Ohio Chapter Champion for the AAP and the Ohio AAP president presented Grand Rounds on UNHS.				X
4. Infant Hearing Subcommittee of BCMH Medical Advisory Committee met four times; provided guidance to the Infant Hearing Program staff on newborn hearing screening issues.				X
5. Infant Hearing Subcommittee of BCMH Medical Advisory Committee discussed genetics component as a standard of care for children with hearing impairments; began partnership with Birth Defects Information System.				X
6. Produced a video, "The Sounds of Life" and distributed to all birthing hospitals in Ohio. The video explains UNHS for parents and caregivers.			X	
7. Site visits made to all nine Regional Infant Hearing Program sub grantees				X
8.				
9.				
10.				

b. Current Activities

A. Monitor and analyze the data on universal newborn hearing screening submitted by birthing hospitals.

B. Provide technical assistance and consultation to hospitals conducting Universal Newborn Hearing Screening programs.

C. Increase outreach to primary care and specialty physicians regarding Universal Newborn Hearing Screening, the follow-up and habilitative services provided through the nine Regional Infant Hearing Programs (RIHP), and the need for communication and coordination between families/physicians/audiologists and RIHPs.

D. Fund, monitor and evaluate through data and site visits the Regional Infant Hearing Programs that follow-up on newborn hearing screening referrals and provide habilitative services to children (up to three years) identified with a hearing loss.

E. Evaluate the effectiveness of the follow-up process by the Regional Infant Hearing Programs.

c. Plan for the Coming Year

A. Monitor and analyze the data on Universal Newborn Hearing Screening (UNHS) submitted by birthing hospitals by developing/updating a QA plan, implementing the quality assurance process, and providing feedback to the birthing hospitals.

B. Provide technical assistance and consultation to hospitals conducting Universal Newborn Hearing Screening Programs.

C. Monitor hospitals' compliance with the legislation requiring UNHS and the associated rules. Explore with Maternity Licensure the feasibility of concurrent monitoring site visits using the protocol developed for UNHS.

D. Continue convening the Infant Hearing Subcommittee of the BCMH Medical Advisory Committee to obtain input and feedback on newborn hearing screening issues, such as

researching the feasibility of incorporating a genetics component.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	8	9.8	9.8	7	7
Annual Indicator	9.5	8.0	7.6	8.4	
Numerator	274500	244593	220000	237500	
Denominator	2888339	3051229	2879927	2815289	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	7	7	7	7	7

Notes - 2002

2001 Current population survey: Ohio's numerator was derived from averaging the number of children under age 18 who are uninsured according to the current population survey. The average of 2000 and 2001 was used as the numerator. The denominator is from census data - number of children in the state under 18.

Notes - 2003

2003 Current population survey: Ohio's numerator was derived from averaging the number of children under age 18 who are uninsured according to the current population survey. The average of 2002 and 2003 was used as the numerator. The denominator is from census data - number of children in the state under 18.

Notes - 2004

2004 data is not yet available.

a. Last Year's Accomplishments

The target for Calendar Year 2003 was 7.0 percent. The actual percent of children without health insurance was 8.4, which is increase from the previous year. Ohio did not meet its target.

FY 2003 MCH Annual Report
Core Performance 13

Percent of Children without Health Insurance

A. Monitor data regarding the rate of uninsured children served through DFCHS funded agencies and FQHCs.

*In FFY02, CFHS child health clinics served 19,994 uninsured children in 26,455 health care visits.
*FQHCS provided 11,730 health care visits for children.
*Clinics funded by the Health Priority Trust Funds provided 10,914 health care visits for children.
*Seven BOHS funded Safety Net Dental Care programs reported 6,435 dental visits for mothers and children who were uninsured and paid for services using the sliding fee schedule offered by the programs.
*BCMH paid Medicaid Spendown for 15 children on the Treatment Program.
*Training seminars were held for public health nurses, local health departments and private providers to improve third party payment information.
*BCMH conducted Public Health Nurse (PHN) open houses with continuing education units to inform them about third party policies/procedures and the necessary steps to help families of CHHCN access all available third party resources.

B. Monitor data regarding the rate of uninsured children through the Current Population Survey.
*An Analysis by the Children's Defense Fund of the recently released (September 2003) Current Population Survey by the U.S. Census for 2002 reveals that 8.9 percent (270,000 est.) children are uninsured in Ohio. In 2001, 8.0 percent of the children were reported uninsured in Ohio's MCH annual report.

C. Work with DFCHS funded projects to provide technical assistance on how to educate and inform consumers to understand and navigate the health care system.
*Child and Family Health Services program funds 79 local agencies and 10 Ohio Infant Mortality Reduction Initiative projects to provide care coordination services to clients and their families.
*Help Me Grow distributed nearly 200,000 publications called Help Me Grow: A Wellness Guide for Mother's-To-Be and Their Babies and Health Diary. This magazine contained a full-page ad for the Healthy Start program. The following is a breakdown of wellness guide distribution: Helpline Consumer Requests -- 3%, State Funded Clinics-29%, Hospitals-19%, Pharmacies-6%, Physicians-20%, other requests-23%.
*BOHS was awarded a HRSA State Oral Health Collaborative Systems (SOHCS) grant, which includes developing oral health screening, educational and referral information for use by HMG coordinators.
*BCMH Parent to Parent Newsletter regularly focuses on providing updates on Health Start/Health Families.
*BCMH assisted Family Voices in sending a newsletter regarding Health Start/Healthy Families.
*BCMH held quarterly meetings with the Parent Advisory Councils (PAC). Parents on PAC share information with other parents of CSHCN.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collected and monitored the number of uninsured/underinsured children served by DFCHS funded clinics: BCMH including Medicaid Spend-down; FQHCs; Free Clinics and charitable vision care.				X
2. Provided health insurance information to providers.				X
3. Screened and referred Child Care Health Consultants' child care applicants to Healthy Start.		X		
4. Referred OPTIONS consumers appropriately to existing systems of				

dental care.		X		
5. Provided training to CFHS/OIMRI project directors on revised program standards regarding Combined Programs Application (CPA) assistance and outreach to enroll clients into Healthy Start.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A. Monitor data regarding the rate of uninsured children served through DFCHS funded agencies and FQHCs.

B. Monitor data regarding the rate of uninsured children through the current population survey.

C. Work with DFCHS funded projects to provide technical assistance on how to educate and inform consumers to understand and navigate the health care system.

c. Plan for the Coming Year

A. Monitor data regarding the rate of uninsured children served through DFCHS funded agencies, FQHCs, Free Clinics, the Ohio Family Health Survey, and the Current Population Survey.

B. Work with DFCHS funded projects to provide information, technical assistance, and/or training as appropriate to providers and consumers on how to understand and navigate the health care system.

C. Work with ODJFS to review and renegotiate ODH/Medicaid Interagency Agreement containing provisions re: Medicaid enrollment and outreach activities.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	92.8	82	82	90	90
Annual Indicator	64.7	82.9	89.0	82.4	
Numerator	578079	739134	840355	944752	
Denominator	893491	891399	944113	1146391	
Is the Data Provisional or				Final	

Final?					
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	90	90	90	90

Notes - 2002

SFY 2001 data: The denominator is actual eligibles up to 21 but not including 21. SFY data is July 1 through June 30th.

Notes - 2003

SFY 2002 data: The denominator is actual eligibles up to 21 but not including 21. SFY data is July 1, 2001 through June 30th, 2002.

Notes - 2004

Data for 2004 is not yet available

a. Last Year's Accomplishments

The target for Calendar Year 2003 was 90 percent. The actual percent of potentially Medicaid-eligible children who received a service paid by the Medicaid program was 82.4 percent. Ohio did not meet the target.

A. Monitor the percentage of Healthy Start eligible children who receive services paid by the Medicaid Program.

1. For FFY99, according to CMS HCFA-416 report, 49 percent of Ohio's EPSDT recipients were screened and 215,773 Medicaid eligible children received dental preventive services.

2. School-based sealant grantees received Medicaid reimbursement to place sealants on 6,764 children; and dental safety net clinics received Medicaid reimbursement for 12,119 visits.

B. Provide assistance in DFCHS funded projects to assist consumers in enrolling in Healthy Start/Healthy Families and in accessing safety net services.

1. All BCMH applications are screened for potential Healthy Start/Healthy Family eligibility.

2. Dental OPTIONS program referred 4,229 people to safety net clinics, county JFS offices or for emergency care only.

3. 41 percent of local CFHS funded projects identyified medicaid enrollment as a priority and provided over 400 hours of Combined Programs Application assistance and over 3,708 hours of care coordination.

4. County Help Me Grow Programs informed families about the Healthy Start program.

C. Collaborate with partners to provide technical assistance, publicize and disseminate Healthy Start information to providers, consumers, and employers.

1. ODH submitted a draft Medicaid Administrative Claiming (MAC) Methodology Guide to OFJFS for public health outreach activities that support effiiicient administration of the Medicaid program.

2. BCMH meets with ODJFS and collaborates with Ohio Chapter AAP Children with Disabilities Committee to facilitate commmunication and service delivery; to promote practice of Medical Home Standards; and to obtain RWJ grant on educating the Amish regarding genetic disorders.

3. Participated collaboratively with Ohio Children's Defense Fund's Covering Kids and Families Initiative and Medicaid committees.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitored the percentage of Healthy Start eligible children who receive services paid by the Medicaid Program.				X
2. Provided assistance in DFCHS funded projects to assist consumers in enrolling in Healthy Start/Healthy Families and in accessing safety net services.				X
3. Collaborated with interdepartmental, state, local agencies and initiatives to provide technical assistance, publicize and disseminate Healthy Start information to providers, consumers, and employers.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A. Monitor the percentage of Healthy Start eligible children who receive services paid by the Medicaid Program.

B. Provide assistance in DFCHS funded projects to assist consumers in enrolling in Healthy Start/Healthy Families and in accessing safety net services.

C. Collaborate with interdepartmental, state, local agencies and initiatives to provide technical assistance, publicize and disseminate Healthy Start information to providers, consumers, and employers.

c. Plan for the Coming Year

A. Monitor the percentage of Healthy Start eligible children who receive services paid by the Medicaid Program.

B. Monitor and maximize Medicaid billing by DFCHS funded agencies.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					
Annual Objective and	**2000**	**2001**	**2002**	**2003**	**2004**

Performance Data					
Annual Performance Objective	1.36	1.4	1.4	1.4	1.4
Annual Indicator	1.5	1.5	1.6	1.7	
Numerator	2269	2318	2391	2546	
Denominator	155721	151140	147832	149828	
Is the Data Provisional or Final?				Provisional	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	1.4	1.4	1.4	1.4	1.4

Notes - 2002

Calendar year data.

Notes - 2003

Calendar year data. 2003 data is preliminary.

Notes - 2004

Data for 2004 is not available.

a. Last Year's Accomplishments

The target for Calendar Year 2003 was 1.4 %. The actual percent of very low birth weight infants among all live births was 1.7. Ohio has not met its goal.

A. Regional Perinatal Centers partnered with March of Dimes (MOD) to present two Prematurity Summits in the largest urban areas of the state. The DFCHS Chief presented at both summits. The Director of the Ohio Chapter of the MOD serves on the state Data Use Consortium (DUC) team which engages professionals concerned with maternal and infant health in a learning process. This team is facilitated by staff from ODH.

B. The six perinatal regions and the State DUC teams have implemented a Perinatal Periods of Risk (PPOR) analytic tool to address the data relative to perinatal mortality disparities and convene focus groups bi-annually for discussion to enhance information about birth outcomes and methods to target resources. Data has been analyzed from 1997 through 2001. Phase II of the PPOR targeting both African American and teen births was implemented and results presented to Birth Outcomes workgroup and to CFHS, OIMRI and RPC project directors in order to target interventions and priority populations.

C. BCFHS bureau staff participated in quarterly meetings of the Ohio Section of ACOG. Solicited input on plans for prenatal smoking cessation and plans for the Regional Perinatal Centers in improving birth outcomes. The Regional Perinatal Centers have been instrumental in coordinating workgroups who are focusing on data, using the information collected in each region and dispersing evidence based standards and guidelines of care. Each region worked with the MOD and hosted a Perinatal Summit to discuss the very low birth weight issues.The Prenatal Smoking Cessation Program (PSCP) contracted a physician to present the "5 A's" at hospital grand rounds to reach more physicians with the "5 A's" Prenatal Smoking Cessation Intervention Training. Vital Statistics, WIC, and Title V prenatal clinic data were used to identify counties with the highest rates of prenatal smoking. Hospitals located within those counties were utilized as training sites.

D. The PSCP submitted an application to participate in an HRSA sponsored Action Learning Lab. This activity brings state partners together to develop an action plan for tobacco prevention and cessation for women of reproductive age, including pregnant women. The Ohio Team consists of representative from the BCFHS, the Ohio section of ACOG, the Planned Parenthood Federation of America, Tobacco Risk Reduction Program and the Ohio Tobacco Use Prevention and Control Foundation. PSCP developed and sought funding for the System-Level Prenatal and Postpartum Tobacco Treatment Pilot to reduce tobacco use among pregnant and postpartum women. The Ohio Chapter of ACOG, Help Me Grow, and the WIC Program pledged access to their respective prenatal service providers to implement the pilot.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Regional Perinatal Centers partnered with March of Dimes to present two Prematurity Summits in the largest urban areas of the state.			X	
2. The six perinatal regions and the State Data Use Consortium teams implemented a Perinatal Periods of Risk analytical tool to address the data relative to perinatal mortality disparities and convene focus groups to share information about birth outcom				X
3. BCFHS bureau staff participated in quarterly meetings of the Ohio Section of ACOG.				X
4. The Prenatal Smoking Cessation Program submitted an application to participate in a HRSA sponsored Action Learning Lab.				X
5. Implemented a perinatal periods of risk approach for analyzing birth outcome data to target interventions in urban communities statewide.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A. Partner with the March of Dimes on the national campaign regarding prematurity.

B. Implement the phase three of the Perinatal Periods of Risk (PPOR) methodology to enhance information from birth outcomes data in order to inform stakeholders and to target Division of Family and Community Health Services (DFCHS) resources.

C. Collaborate with the Ohio section of the American College of Obstetricians and Gynecologists (ACOG) to identify and implement strategies that impact birth outcomes.

D. Partner with the ODH-Tobacco Risk and Reduction Program; Planned Parenthood Affiliates of Ohio; American College of Obstetricians and Gynecologists; Ohio Tobacco Use Prevention and Control Foundation; and other stakeholders to develop and implement strategies for perinatal smoking cessation.

E. Conduct an assessment of the effectiveness of Child and Family Health Services (CFHS) programs to impact birth outcomes.

F. Fund, monitor, and provide technical assistance to the Child and Family Health Services (CFHS), Ohio Infant Mortality Reduction Initiative (OIMRI) and the Regional Perinatal Centers (RPC) projects.

G. Analyze and report best practices for five birth outcomes performance measures (National 15, 17, 18 and State 11 and 7).

c. Plan for the Coming Year

A. Collaborate with health care providers to ensure all women of child bearing age are screened for risk factors associated with VLBW and are provided appropriate follow-up such as assessment, referral, and/or counseling.

B. Collaborate with health care providers to ensure all women of childbearing age are screened for substance abuse and provided appropriate follow-up such as assessment, referral, and/or counseling.

C. Collaborate with agencies and organizations (ADAMH, ODADAS, etc.) to develop a resource inventory that lists the appropriateness, accessibility, affordability, availability, acceptability of nutritional, psycho-social, and substance abuse services and educational resources.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	5.6	6.5	6.5	5	5
Annual Indicator	7.3	7.0	5.7	5.1	
Numerator	60	57	46	41	
Denominator	816868	816868	811851	810850	
Is the Data Provisional or Final?				Provisional	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5	5	5	5	5

Notes - 2002

Calendar year data. Vital statistics death records beginning with 1999 are coded using ICD-10.

Notes - 2003

Calendar year data. Vital statistics death records beginning with 1999 are coded using ICD-10.

2003 data is preliminary.

Notes - 2004

Data for 2004 is not available.

a. Last Year's Accomplishments

The target for Calendar Year 2003 was 5.0 deaths per 100,000. The actual rate was 5.1. Based on provisional Vital Statistics data, Ohio nearly met its target.

A. Conduct resource mapping process to identify counties with increased teen suicide rates and match to community resources for those counties.
*Began process of creating survey and identifying target counties to survey. Process will be continued in 2005 grant year.

B. Examine Child Fatality Review data and share results with DCFHS funded grants that work with teens.
*Child Fatality Review reported 31 suicides in 2002. Circumstances and contributing factors were analyzed and shared at meetings with CFR Advisory Committee, ODH staff, statewide CFHS projects, Dept. of Mental Health staff, child protective service workers, and other statewide stakeholders. The report is published and available to all on the ODH Web site.

C. Educate Pediatricians, Local Health Departments, CFHS clinics and FQHC's in the identification of mental health issues and proper referral for treatment.
*Conducted two trainings to new Public Health Nurses on teen suicides in Ohio. There were nurses present from local health districts throughout Ohio.

D. Collaborate with the Ohio Department of Mental Health and the 10 regional mental health coalitions to identify and support depression awareness and intervention activities to target groups (ie school nurses, school staff, community coalition groups).
*The ODH is a member of the Ohio Suicide Prevention Team (SPT). During this past year, the SPT developed a suicide prevention website which was launched on July 1, 2004, and provided two statewide workshops (Gatekeepers "Train the Trainer" and "The QPR of Suicide").
*There are now 48 counties with suicide prevention coalitions.

E. Collaborate with the Suicide Prevention Committee and share state wide strategies.
*ODH partnered with the Ohio Department of Mental Health, the ADAMH Board and the Ohio Commission on Dispute Resolution and Conflict Management to work as a subcommittee of the SPT to form a statewide speaker's bureau, with both youth and adult speakers.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conducted resource mapping to identify counties with increased teen suicide and matched community resources for those counties.				X
2. Examined Child Fatality Review data and shared results with DFCHS funded grants that work with teens.				X
3. Trained pediatricians, local health departments, CFHS clinics and FQHCs in the identification of mental health issues and proper referral for				X

treatment.				
4. Collaborated with the Ohio Depatrtment of Mental Health and 10 regional mental health coalitions to identify and support depression awareness and intervention activities.				**X**
5. Collaborated with the Suicide Prevention Committee and shared statewide strategies.				**X**
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A. Conduct resource mapping process to identify counties with increased teen suicide rates.

B. Examine data, including Child Fatality Review, Youth Risk Behavior Survey, and Vital Statistics, and share results with DCFHS funded grants that work with teens and the Ohio Department of Mental Health.

C. Conduct activities aimed to educate Pediatricians, Local Health Departments, CFHS clinics and FQHC's in the identification of mental health issues and proper referral for treatment.

D. Collaborate with the Ohio Department of Mental Health and the 10 regional mental health coalitions to identify and support depression awareness and intervention activities to target groups (i.e. school nurses, school staff, community coalition groups, school based mental health).

E. Collaborate with the Suicide Prevention Team and share state wide strategies.

c. Plan for the Coming Year

A. Monitor data, including Child Fatality Review, Youth Risk Behavior Survey, and Vital Statistics, and share results with state and county partners, including but not limited to DCFHS funded grants that work with teens and the Ohio Department of Mental Health.

B. Conduct activities to educate health care providers, educators and others who interact directly with children and youth in the identification of mental health issues, accessing available resources and making referrals for treatment.

C. Collaborate with state and county partners, including but not limited to the Suicide Prevention Team and the Child Fatality Review Board, and share state wide strategies.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance	**2000**	**2001**	**2002**	**2003**	**2004**

Data					
Annual Performance Objective	66	71	71	72	72
Annual Indicator	69.6	70.3	70.5	63.3	63.3
Numerator	1580	1629	1685	1612	1612
Denominator	2269	2318	2391	2547	2547
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	74	74	74	74	74

Notes - 2002

Calendar year data.

Notes - 2003

Calendar year data. 2003 data is preliminary data from Ohio Vital Statistics.

Notes - 2004

Calendar year. 2004 data is not available. 2004 data is an estimate using 2003 data. 2003 data is preliminary.

a. Last Year's Accomplishments

The target for calendar year 2003 was 72 percent. The actual percent of VLBW infants delivered at facilities for high-risk deliveries and neonates was 63.3. Based on provisional Vital Statistics data, Ohio did not meet its target.

A. The Bureau of Child and Family Health Services began the preliminary work to conduct research to determine why all VLBW babies are not born at high risk facilities. The results will be shared with the Regional Perinatal Centers and other stakeholders.

B. The Regional Perinatal Centers analyzed the data regarding outcomes of VLBW births and provided arenas for professional discussion promoting best practice strategy development.

C. 100 percent of the CFHS funded prenatal clinic sites used the prenatal care risk assessment tool at least once during prenatal care. Sixty-one prenatal clinic sites were funded in Ohio.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conducted preliminary studies to determine why all VLBW infants were not born at high risk facilities.				X
2. Regional Perinatal Centers analyzed data regarding outcomes of VLBW births to promote discussion regarding best practice strategy development.				X
3. All CFHS funded prenatal clinic sites used the prenatal care risk			X	

assessment tool at least once during prenatal care.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A. Analyze birth outcomes information to determine the demographics of very low birth weight babies to monitor the appropriateness of the delivery facility.

B. Implement the phase three of the Perinatal Periods of Risk (PPOR) methodology to enhance information from birth outcomes data in order to inform stakeholders and to target Division of Family and Community Health Services (DFCHS) resources.

C. Fund, provide technical assistance, and monitor the success of the Regional Perinatal Centers (RPCs) in meeting the competitive federal fiscal year 2005 grant requirements.

D. Analyze and report best practices for five birth outcomes performance measures (National 15, 17, 18 and State 11 and 7).

c. Plan for the Coming Year

A. Design an analysis of outcomes by birth weight, survival, proximity to Level III facilities by county of residence, length and method of transports, risk factors, and morbidity

B. Educate professionals on the importance of maternal referral of patients who are at high risk for preterm delivery to appropriate facilities.

C. Fund, provide technical assistance, and monitor the success of Regional Perinatal Centers (RPCs) in meeting the competitive federal fiscal year 2005 grant requirements.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	87	87	87	88	88
Annual Indicator	84.9	85.8	87.8	87.8	
Numerator	132134	129646	128039	130276	
Denominator	155721	151140	145785	148379	

Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	88.5	88.5	88.5	88.5	88.5

Notes - 2002

Calendar year data.

Notes - 2003

Calendar year data. The denominator is less than the total birth because we excluded all missing data. 2003 birth data is preliminary.

Notes - 2004

2004 data is not available.

a. Last Year's Accomplishments

The target for calendar year 2003 was 88 percent. The actual percent of infants born to pregnant women receiving prenatal care beginning in the first trimester was 87.8. Based on provisional Vital Statistics data, Ohio nearly met its target.

A. Implemented a perinatal periods of risk approach for analyzing birth outcome data to target interventions in urban communities statewide. Reviewed and analyzed birth outcome data, including MATCH data, and provided TA to DFCHS funded programs accordingly.

B. "Reviewed grant applications and MATCH data to identify CFHS programs focusing on early prenatal care. Provided TA to programs as needed. Reviewed and refined the OIMRI data entry process. Funded 12 OIMRI programs, with community health workers, in counties with late entry into prenatal care and high infant mortality rates.

C. Shared information with legislators, policy makers, and governor's office via the ODH Legilative liason as needed.

D. "Funded and and provided TA to 79 CFHS projects. Analyzed MATCH data and identified that within CFHS prenatal clinics, more than 50 percent of perinatal clients are entering prenatal care within the first trimester. Shared resources, education materials and best practices with CFHS sites at monitoring visits and project director meetings. Funded 12 OIMRI programs and provided technical assistance (TA) to all 12 projects. On site monitoring visits were made to five projects. OIMRI staff communicated with funded agencies at each Community Care Coordination Collaborative meeting. Funded six Regional Perinatal Centers and provided TA and on site monitoring visits to all six projects. Monitored the standardized care coordination training for community care coordinators provided at two community colleges.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Implemented a Perinatal Periods of Risk approach for analyzing birth outcomes data to target interventions in urban communities statewide.				**X**
2. Shared information with legislators, policy makers, and the governor's office via the ODH Legislative liasion as needed.			**X**	

3. Funded and provided technical assistance to CFHS and OIMRI projects.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A. Implement the phase three of the Perinatal Periods of Risk (PPOR) methodology to enhance information from birth outcomes data in order to inform stakeholders and to target Division of Family and Community Health Services (DFCHS) resources.

B. Implement the National Association of City and County Health Officials (NACCHO) Strategic Decisions for Service Delivery at the local Child and Family Health Services project level to determine the most effective use of resources that can impact birth outcomes.

C. Fund, monitor, and provide technical assistance to the Child and Family Health Services (CFHS), Ohio Infant Mortality Reduction Initiative (OIMRI) and the Regional Perinatal Centers (RPC) projects.

D. Analyze and report best practices for five birth outcomes performance measures (National 15, 17, 18 and State 11 and 7).

c. Plan for the Coming Year

A. Compare the demographics and locations of the populations served by CFHS, OIMRI, HMG, WIC, FQHCs, and Medicaid providers to the demographics and locations of the populations at risk for not receiving prenatal care in the first trimester.

B. Provide technical assistance to DFCHS-funded agencies to strengthen referral and follow-up activities between family planning services and prenatal care services.

C. Provide technical assistance to funded projects to ensure that they educate women about the importance of prenatal care and pre/inter-conception care.

D. Assess the cultural competency and acceptability of prenatal care services in ODH funded clinics.

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *The unintended pregnancy rate per thousand in women of childbearing age.*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	380	370	370	360	360
Annual Indicator	424.9	406.9	432.4	432.4	
Numerator	63276	58874	62751	62751	
Denominator	148928	144688	145132	145132	
Is the Data Provisional or Final?				Provisional	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	350	380	380	380	

Notes - 2002

PRAMS data is available for 1999, 2000, 2001 and 2002. Data for live births do not include residents who gave births out of state. 2003 birth data is preliminary.

The year 1999 represents the change from program data used to measure this indicator to the use of the population-based PRAMS data. Prior year data was from Child and Family Health Services (CFHS). Targets are changed to reflect the change in data source and will be monitored and re-evaluated as experience with these data increases.

Notes - 2003

2003 data is estimate because 2003 PRAMS data are not available.

Notes - 2004

Data for 2004 not yet available.

a. Last Year's Accomplishments

The target for Calendar Year 2002 was 370 per thousand women of child bearing age. The actual unintended pregnancy rate was 432.4 Ohio did not meet the target.

A. All family planning providers funded by BCFHS received a technical assistance visit. Eight providers received a comprehensive site visit that included evaluation of clinical, fiscal, administrative and outreach activities of their agency. ODH participated in The Impact of Family Planning Services Availability study conducted by Dartmouth College Center for Evaluative Clinical Services and by CDC. The study objectective was to identify strategies that might reduce births to teens and/or uninteded births by making family planning services more available to populations at high risk of these problems. The specific aim is to determine whether the risk of teen births and uninteded births is associated with geographic availability of family planning services; structural factors that encourage utilization; and cultural concordance between patients and service providers. Data sources include Ohio PRAMS; state birth certificate data; family planning services data; and private provider data. The data collection phase of the study was completed and analysis is underway. Preliminary results indicate variations in family planning access by type of clinic and type of staff.

B. Family Planning services were targeted to women at highest risk, teens, African-American women, and clients whose incomes were at or below 100 percent of the Federal Poverty Level. The average of low-income clients served increased from 59 percent to 61 percent from 2003-

2004.

C. Information on protective activities for clients was provided to providers. All providers were provided policies and procedures for 1.) counseling all adolescents to resist sexual coersion, 2.) mandatory reporting laws for Ohio in regards to sexual abuse to minors, and 3.) training opportunities provided by the Ohio Domestic Violence Network to for clinicians who screen patients for risk behaviors of tobacco use, illicit drug use, alchohol use and domestic violence.

D. The Family Planning program identified programs and interventions that encouraged male involvement. Providers were directed to include services to males that include family planning and STD treatment and education.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Site visits were made to all BCFHS-funded family planning providers and technical assistance provided.				X
2. Family Planning service targeted to women at highest risk: teens. The percentage of low income clients served in family planning clinics increased from 59% to 61% from 2003-2004.	X			
3. Information on protective activities for clients was provided to providers.				X
4. The Family Planning Program identified programs and interventions that encouraged male involvement.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A. Fund, monitor, evaluate and provide technical assistance to local family planning agencies to affect outcome measures.

B. Target family planning program services to those women at highest risk to have poor birth outcomes.

C. Ensure that postpartum clients are connected to family planning services.

c. Plan for the Coming Year

This measure will be discontinued and will be replaced with a new state measure on increasing the capacity of the state to decrease unintended pregnancy among populations at high risk for poor birth outcomes.

State Performance Measure 5: *The percentage of low income children who are*

overweight.

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	8.7	8.9	8.9	8.9	8.9
Annual Indicator	10.3	11.8	11.9	12.5	
Numerator	36667	29519	30497	25999	
Denominator	356869	250164	256275	207992	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	8.9	8.9	8.9	8.9	

Notes - 2002

Data source: Ohio's CDC Pediatric Nutrition Surveillance System [PedNSS]. Included infants and children aged less than 5 years. The visible difference between this year's data and last year's was due to a change in methodology (by CDC) for data analysis. Previous year's data were based on visits, allowing duplicate information on individual children. For 2001, each child was represented only once and therefore data were unduplicated, accounting for the low numbers.

Notes - 2003

Data source: Ohio's CDC Pediatric Nutrition Surveillance System [PedNSS]. Included infants and children aged less than 5 years. The difference between 2000 and 2001 data was due to a change in methodology (by CDC) for data analysis. Previous year's data were based on visits, allowing duplicate information on individual children. From 2001, each child was represented only once and therefore data were unduplicated, accounting for the low numbers.

Notes - 2004

Data for 2004 not yet available

a. Last Year's Accomplishments

The target for Calendar Year 2003 was 8.9 percent. The actual percent of Ohio's low income children under age five years who were overweight was 12.5. Ohio did not meet its target.

A. PedNSS data for 2002 were distributed to projects and posted on ODH's website. MATCH data was reviewed for the following counties: Ashtabula, Butler, Greene, Huron, Lawrence, Lorain, Lucas, Marion, Mercer, Sandusky, Seneca, and Wood.

B. The Bureau of Nutrition Services provided technical assistance to all WIC projects as needed. MATCH data was reviewed by MCH nutritionist for the counties mentioned under strategy A. New nutrition educational materials were distributed through mailings to WIC and CFHS projects and at the Project Directors' meetings.ODH nutrition cards were distributed as needed. They are also posted on the ODH website. Buckeye Best surveys were sent to schools. Obesity position center was not developed due to staffing issues.

C. CFHS Child and Adolescent Program Standards have been revised and new BMI guidelines have been included. Currently, BCHSSD is conducting a BMI study of third graders in Ohio. Students who have parent permission are weighed and measured. This activity will provide a baseline of the percentage of overweight kids at this developmental time period. This data will assist policy developers, program planners and school boards of education in assessing the nutritional needs of kids in their counties.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. PedNSS data for 2002 were distributed to projects and posted on ODH's website.				X
2. Technical assistance on overweight was provided to all WIC projects as needed and nutrition education materials distributed.				X
3. CFHS Child and Adolescent Program Standards were revised and new BMI guidelines included.				X
4. BCHSSD initiated a BMI survey of third graders in Ohio.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A. Monitor the growth of children through WIC (via PedNSS) and MATCHr data.
* Review PedNSS data on a regular basis to determine need for technical assistance
* Review MATCHr data before regularly scheduled CFHS site visits and periodically to determine need for technical assistance in counties with a high percentage of kids with inappropriate weights.

B. Provide technical assistance to Division of Family & Community Health Services funded projects with high percentage of children with inappropriate weight.
* Review MATCH and other available data to determine need for technical assistance.
* Distribute appropriate educational materials at regularly scheduled project directors' meetings and or mailings.
* Provide educational tools (i.e. nutrition cards) to local projects for use with overweight children and their care givers.

C. Coordinate nutrition activities and trainings to provide a Department wide coordination of the obesity initiative.
* Work with schools and other agencies in the community to address the issue of childhood obesity.
* Provide training to BCFHS health professionals with regards to motivational interviewing which has been proven to as an effective technique in behavior modification.
* Revise CFHS Child and Adolescent Program Standards to include new BMI guidelines and additional resources as applicable.

c. Plan for the Coming Year

This measure will be discontinued and will be replaced with a measure designed to monitor the degree of overweight and risk for overweight among 3rd graders in public schools.

State Performance Measure 7: *Percentage of 3rd grade children with obvious need for dental care.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	20%	24	23	22	21
Annual Indicator	29.0	25.7	30.9	34.6	
Numerator	360	319	422	437	
Denominator	1241	1240	1366	1262	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	20	20	20	20	20

Notes - 2002

Data drawn from an annual survey of 25 sentinel schools providing a population based estimate for the state.

Notes - 2003

Sentinel Schools

Background: The Ohio Department of Health (ODH) has conducted oral health surveys of schoolchildren since 1987-88. The 1987-88 and 1992-93 surveys were DMFS (Decayed, Missing, Filled Surface) epidemiological surveys of a statewide probability sample. In 1998-99, the ODH revised its methodology to a screening survey that mirrored the model it was developing for the Association of State and Territorial Dental Directors. In addition, the sampling was done at the county level and was limited to grades 1-3, where the previous survey included additional grades.

After the 1998-99 survey was completed, the ODH contracted with the Ohio State University Biostatistics program to select a purposive sample of 25 schools. The sample would be both representative of the full sample of 336 schools and would limited to schools that were cooperative in 1998-99. ODH used a subjective 5-point scale to assess each school's level of cooperation. Only schools in the two highest categories were considered for the sentinel school sample. Only third graders are screened in the sentinel surveys.

Purpose: The purposes of selecting the sample of sentinel schools were:
• to generate annual estimates of oral health status between the larger statewide surveys that

were conducted at 5-6 year intervals. These estimates would serve two purposes
? a basis for required reporting of MCH Block Grant performance measures, and
? as part of an oral health surveillance system to examine trends
• to validate the sentinel schools approach by screening the sentinel schools along with the new sample of schools selected for the next large survey (2003-04 or 2004-05).

Dr. Stacey Hoshaw-Woodward, of the OSU Biostatistics Program, developed the model used to select sentinel schools.

Notes - 2004

Data for 2004 is not yet available.

a. Last Year's Accomplishments

The target for calender year 2003 was 22 percent. The actual percent of 3rd grade children with obvious need for dental care was 34.6. Ohio did not meet its target.

A. Continue momentum for state level planning to improve access to dental care.
1. The recommendations of the Director of Health's Task Force (DTF) on Access to Dental Care were updated (www.odh.state.oh.us/ODHPrograms/ORAL/Rpt2000/DTFRpt04.pdf)
2. The Bureau Chief is working with the Ohio Dental Association (ODA) to develop the ODA action agenda for carrying out the recommendations of the DTF.

B. Fund dental safety net programs and help build the infrastructure of these programs.
1. Funded seven agencies to provide dental care to 11,831 high-risk children and women.
2. Four renewal and two new dental HPSA applications were submitted to the Bureau of Health Professions.
3. Provided technical assistance to nine communities interested in starting dental clinics.
4. Provided support for the newly created state dentist loan repayment program, nine dentists applied.

C. Collaborate with the Ohio Dental Association to administer OPTIONS, the statewide dental program for Ohioans with no dental insurance or resources to pay for care.
Reported under Other Program Activities

D. Maintain data on oral health status, resources and access; provide data and technical assistance to communities.
Oral screenings were conducted at 25 sentinel schools and 15 sentinel Head Start centers. Data were analyzed and will be posted on the web. A manuscript on the Head Start survey was accepted for publication in the Journal of Pediatric Dentistry.

E. Facilitate local partnerships, help local coalitions assess the oral health needs of their clients and implement strategies to meet those needs.
1. Bureau staff provided TA to 15 communities on different oral health initiatives.
2. Tools to prioritize counties for community development assistance were drafted to assess community need and readiness. Assistance has been requested from CDC on this project.
3. The Ohio Head Start Oral Health Forum was held April 2004, 82 people helped develop a plan to improve the oral health of Ohio's Head Start children. Two agencies were contracted to develop new TA approaches, another is developing a plan to increase the number of dentist serving Head Start children.

F. Prevent dental caries through community-based fluoride promotion.
1. BOHS staff worked with the Healthy Smiles for Lancaster committee on a water fluoridation campaign. The measure failed by only 521 votes out of 15,647 votes cast.
2. Eight Ohio communities were presented certificates of appreciation for 50 or more years of fluoridation.
3. The Bureau disbursed $62,275 to four communities for fluoridation equipment.

4. 48,796 students in 214 elementary schools participated in the school fluoride mouthrinse program.
5. Lists of fluoride levels in public water systems were updated for 72 of Ohio's 88.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Recommendations of the Director of Health's Task Force on Access to Dental Care was updated; Oral Health Bureau Chief working with the Ohio Dental Association (ODA) to develop ODA action agenda to carry out recommendations.				X
2. Funded dental safety net programs and helped build infrastructure of these programs.				X
3. Collaborated with the Ohio Dental Association to administer OPTIONS, the statewide dental program for Ohioans with no dental insurance or resources to pay for care.				X
4. Maintained data on oral health status, resources and access; provided data and technical assistance to communities.				X
5. Conducted oral health screenings at 25 sentinel schools and 15 sentinel Head Starts.			X	
6. A manuscript on the Head Start survey was accepted for publication in the Journal of Pediatric Dentistry.				X
7. Facilitated local partnerships, helped local coalitions assess the oral health needs of their clients and implemented strategies to meet those needs.				X
8. At an Ohio Head Start Oral Health Forum held in April, 2004, 82 people helped develop a plan to improve the oral health of Ohio's Head Start children.				X
9. Bureau of Oral Health staff worked with the Healthy Smiles for Lancaster committee on a water fluoridation campaign. The measure failed by only 521 votes out of 15,647 votes cast.				X
10. 48,796 students in 214 elementary schools participated in the school fluoride mouthrinse program.			X	

b. Current Activities

A. Continue state level planning to improve access to dental care.
1. Work with the Ohio Dental Association and appropriate state agencies to implement recommendations of the Director's Task Force on Access to Dental Care.
2. Support and participate in Ohio Coalition for Oral Health (OCOH) activities.

B. Fund, monitor, and evaluate dental safety net programs and help build the infrastructure of safety net dental programs.
1. Fund, monitor and provide technical assistance to 13 local agencies to provide dental care to Ohioans with poor access to oral health services.
2. Identify and assist communities interested in establishing or renewing federally designated dental HPSAs.
3. Administer the dentist state loan repayment program.

C. Maintain current statewide data on oral health status, resources and access, provide data

and technical assistance to communities.
1. Conduct oral health surveys to assess the oral health status, treatment needs of Ohio children in Head Start and third grade.
2. Survey key groups (dentists, social service agencies) working with Ohioans having difficulty obtaining dental care.
3. Update and distribute dental safety net listing.
4. Update oral health access-related data in county profiles for state and local use.

D. Facilitate local partnerships, help local coalitions assess the oral health needs of their clients and implement strategies to meet needs.
1. Provide consultation and technical assistance to communities interested in developing dental partnerships/coalitions.
2. Maintain county-specific narratives on oral health status and resources.
3. Initiate contacts to start new dental partnerships/coalitions in counties ranked as priority for community development activities.
4. Monitor the percentage of Ohio Head Start children who have received dental treatment, using Region V Program Information Report data.
5. Support and implement, where feasible, the strategies and actions of the Ohio Head Start Oral Health Action Plan developed through the Ohio Head Start Oral Health Forum.
6. Fund, monitor and provide technical assistance to local projects to pilot test the Head Start oral health systems models recommended in the Ohio Head Start Oral Health Action Plan.

E. Prevent dental caries through community-based fluoride promotion.
1. Identify and prioritize communities not optimally fluoridated utilizing an assessment tool that objectively scores communities on several weighted parameters.
2. Provide financial assistance to communities beginning to fluoridate and to communities needing to purchase new equipment.
3. Provide, monitor and assess the Fluoride Mouthrinse program in communities without optimal fluoridation or with high free and reduced cost meal program participation.
Improve quality of data and access to information on fluorides and fluoridation by revising and updating information to the ODH website.

c. Plan for the Coming Year

This measure is being discontinued and will be replaced with a similar measure: Percentage of 3rd grade children with untreated caries.

State Performance Measure 9: *The percentage of children with elevated blood lead levels as defined by the Centers for Disease Control and Prevention*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	5.0	6	6	5	5
Annual Indicator	7.8	7.2	5.3	4.2	
Numerator	8101	6705	5669	4779	

Denominator	103383	93118	106613	113276	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5	5	5	5	

Notes - 2002

[CY 2001]: Levels reflect the highest confirmed test for the current year. Child may have been screened in previous years.

Changes to standards in 1998 and program change to targeted screening in 1999 are reflected in the changing numerators and denominators.

Notes - 2003

[CY 2003]: Levels reflect the highest confirmed test for calender year 2003. Child may have been tested in previous years. Data is unduplicated.

Notes - 2004

Data not available at this time.

a. Last Year's Accomplishments

The target for Calendar Year 2003 was 5.0 percent. The actual percentage of Ohio children with elevated blood lead levels was 4.2. Ohio met its target.

A. "The Ohio Childhood Lead Poisoning Prevention Program (OCLPPP) funded 4 Lead Regional Resource Centers (Seneca Co., Cincinnati, Cleveland and Mahoning Co.) that provided education on nutrition, assisted in outreach initiatives and coordinated screening efforts. The Statewide Lead Education Committee met quarterly to plan and develop program strategies to educate/increase awareness and improve physician compliance with screening/follow-up. OCLPPP provided promotional ideas/technical assistance to sub-grantees during Lead Awareness Week.

B. "OCLPPP implemented case management follow-up for cases of lead poisoning > 45 ug/dL which require chelation. 420 public health lead investigations were conducted in the homes of children that presented with a blood lead level > 10 ug/dL. The PLANET program was presented to approximately 985 healthcare providers since June 2001. OCLPPP has worked with ODJFS to increase provider awareness of the state's new requirements around mandatory blood lead testing of children at risk for lead poisoning.

C. "The CY 2003 data from the STELLAR database and the Medicaid Claims and Eligibility databases were matched. Of the approximately 108,000 children in STELLAR, there were 67 percent matched in the Medicaid system. This demonstrates lead screening of 42 percent of 1 year olds and 36 percent of 2 years olds enrolled in Medicaid. There was a 3.5 percent increase in the in the 1 and 2 year old lead testing rate from calendar year 2002. (Source: Data Harmonization -- STELLAR and Medicaid Claims/Eligibility Data.)

D. "Local health departments collaborated with neighborhood groups, housing agencies and Community Action agencies to increase awareness of childhood lead poisoning in targeted neighborhoods (including supplies/instructions for cleaning). Each local agency receives a list of locations participating in the HEPA Vacuum loaner program; families are provided with an instructional video tape with the vaccuum. In-services to staff and lead screenings of children enrolled in Head Start programs were done in many communities.

E. "The Lead Advisory Council, comprised of representatives from various state and local agencies as well as private non-profit and advocacy groups, met monthly to develop a statewide elimination plan (goal of elimination by 2010). OCLPPP participated in a lead poisoning collaborative with ODJFS; collaborated with the ODH WIC program to implement lead dust testing in seven WIC clinics; and worked to decrease the disparity of lead poisoning in racial, ethnic, and cultural groups.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Ohio Childhood Lead Poisoning Prevention Program funded 4 Lead Regional Resource Centers that provided education on nutrition, assisted in outreach initiatives and coordinated screening efforts.				X
2. The Ohio Childhood Lead Poisoning Prevention Program implemented case management follow-up for cases of lead poisoning >45ug/dL which require chelation. Conducted public health lead investigations in the homes of children with blood lead levels >10ug		X		
3. Worked to increase provider awareness of the state's new requirements around mandatory blood lead testing.				X
4. Matched CY 2003 data from STELLAR database and the Medicaid Claims and Eligibility databases. Of Medicaid clients, 42% of 1 year olds and 36% of 2 year olds were screened, a 3.5% increase from CY 2002.				X
5. Local health departments collaborated with neighborhood groups, housing agencies and Community Action agencies to increase awareness of childhood lead poisoning in targeted neighborhoods.				X
6. The Lead Advisory Council, comprised of representatives from various state and local agencies as well as private non-profit and advocacy groups, met monthly to develop a statewide elimination plan.				X
7.				
8.				
9.				
10.				

b. Current Activities

A. Increase public awareness on the health effects of childhood lead poisoning by providing funds to four Lead Regional Resource Centers for statewide education and outreach.

B. Increase compliance with blood lead screening standards and follow-up of confirmed cases by physicians.

C. The number of children enrolled in Medicaid that receive a blood lead test will increase by 6 percent. Increase primary prevention efforts through collaboration with local agencies and intra and inter agency programs.

D. Coordinate with inter-agency partners to plan and implement program strategies and activities in support of childhood lead poisoning prevention.

E. Decrease the disparity of lead poisoning in racial, ethnic, and cultural groups.

c. Plan for the Coming Year

This measure is being discontinued and will be replaced with: Increase the proportion of children who receive age and risk appropriate screenings for lead, vision, hearing and oral health.

State Performance Measure 11: *The low birth weight rate (LBW) per 100 live births*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	7.9	7.7	7.7	7.6	7.5
Annual Indicator	7.9	8.0	8.3	8.5	
Numerator	12326	12123	12263	12703	
Denominator	155721	151140	147832	149828	
Is the Data Provisional or Final?				Provisional	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	7.5	7.5	7.5	7.5	7.5

Notes - 2002

Data for 2002 is not available. Data for 2002 will be available in 2004.

Notes - 2003

Calendar year data. 2003 birth data is preliminary.

Notes - 2004

2004 data is not available.

a. Last Year's Accomplishments

The target for Calendar Year 2003 was 7.6 per 100 live births. The actual low birth weight rate (LBW) was 8.5. Based on provisional Vital Statistics data, Ohio did not meet its target.

A. Regional Perinatal Centers partnered with March of Dimes to present two Prematurity Summits in the largest urban areas of the state. The Dr. Schor presented at both summits. The Director of the Ohio Chapter of the MOD served on the Ohio Data Use Consortium team which engaged professionals concerned with maternal and infant health in a learning process.

B. BCFHS bureau staff participated in quarterly meetings of the Ohio Section of ACOG and solicited input on plans for prenatal smoking cessation and Regional Perinatal Centers in improving birth outcomes. The Prenatal Smoking Cessation Program (PSCP) submitted an application to participate in an Action Learning Lab sponsored by HRSA. The activity will bring state partners together to develop an action plan for tobacco prevention and cessation for women of reproductive age, including pregnant women. The Ohio Team consists of staff from

BCFHS, ACOG, the Planned Parenthood Federation of America, Tobacco Risk Reduction Program & the Ohio Tobacco Use Prevention and Control Foundation. Funding was sought for the System-Level Prenatal and Postpartum Tobacco Treatment Pilot to reduce tobacco use among pregnant and postpartum women. The Ohio Section of ACOG, Help Me Grow, and WIC program have pledged to implement the pilot.

C. A document that summarized best practices that can impact prematurity and low birth weight was developed and shared with the Ohio Birth Outcomes workgroup as well as with local CFHS project directors. The Prenatal Smoking Cessation Program submitted an application to participate in an Action Learning Lab. This activity brings state partners together to develop an action plan for tobacco prevention and cessation for women of reproductive age, including pregnant women. The Ohio Team consists of representative from the BCFHS, ACOG, the Planned Parenthood Federation of America, Tobacco Risk Reduction Program and the Ohio Tobacco Use Prevention and Control Foundation. Funding was sought for the System-Level Prenatal and Postpartum Tobacco Treatment Pilot to reduce tobacco use among pregnant and postpartum women. The ACOG, Help Me Grow, and the WIC program have pledged access to implement the pilot.

D. The six perinatal regions and the State Data Use Consortium teams have implemented a Perinatal Periods of Risk analytic tool to address the data relative to perinatal mortality disparities and convene focus groups bi-annually for discussion to enhance information about birth outcomes and methods to target resources. Data has been analyzed from 1997 through 2001. The information was shared with Child and Family Health Services Program projects.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Regional Perinatal Centers partnered with the March of Dimes to present two Prematurity Summits in the largest urban regions of the state.				X
2. Bureau of Child and Family Health Services bureau staff participated in quarterly meetings of the Ohio Section of ACOG and solicited input on plans for prenatal smoking cessation and Regional Perinatal Centers in improving birth outcomes.				X
3. The Prenatal Smoking Cessation Program submitted an application to participate in an Action Learning Lab sponsored by HRSA.				X
4. A document that summarized best practices that can impact prematurity and low birth weight was developed and shared with the Ohio Birth Outcomes workgroup as well as with local CFHS project directors.				X
5. The six perinatal regions and the State Data Use Consortium teams have implemented a Perinatal Periods of Risk analytic tool to address the data relative to perinatal mortality disparities and convene focus groups bi-annually for discussion.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A. Partner with the March of Dimes on the national campaign regarding prematurity.

B. Implement the phase three of the Perinatal Periods of Risk (PPOR) methodology to enhance information from birth outcomes data in order to inform stakeholders and to target Division of Family and Community Health Services (DFCHS) resources.

C. Collaborate with the Ohio section of the American College of Obstetricians and Gynecologists (ACOG) to identify and implement strategies that impact birth outcomes.

D. Partner with the Tobacco Use Prevention Control Foundation (TUPCF), March of Dimes, and other stakeholders to develop and implement strategies for perinatal smoking cessation.

E. Conduct an assessment of the effectiveness of Child and Family Health Services (CFHS) programs to impact birth outcomes.

F. Fund, monitor, and provide technical assistance to the Child and Family Health Services (CFHS), Ohio Infant Mortality Reduction Initiative (OIMRI) and the Regional Perinatal Centers (RPC) projects.

G. Analyze and report best practices for five birth outcomes performance measures (National 15, 17, 18 and State 11 and 7).

c. Plan for the Coming Year

This measure is being discontinued and will be replaced with a measure that focuses on black low birth weight.

State Performance Measure 12: *Implementation of a statewide Child Fatality Review (CFR) System*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	1	1,2	1234	4	4
Annual Indicator	1	2	3	4	4
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	4	4	4	4	

Notes - 2002

This is a process measure that includes the following steps:

1. Convene a state level CFR team to develop standardized protocol for local CFR teams.

2. Work will state level CFR teams to develop training materials, manuals and training sessions for local CFR's.

3. State level team will review annual reports from community based CFR teams and prepare statewide report.

4. Encourage all Ohio county to implement [sic]

Notes - 2003

1. Convene a state level CFR team to develop a standardized protocol for local CFR teams.

2. Work with state level CFR teams to develop training materials, manuals and training sessions for local CFRs.

3. State level team will review annual reports from community based CFR teams and prepare statewide reports.

Notes - 2004

Data for 2004 is not available.

a. Last Year's Accomplishments

This is a process measure that includes the following steps:
1. Convene a state level CFR team to develop standardized protocol for local CFR teams;
2. Work with state level teams to develop training materials, manuals and training sessions for local CFR's;
3. State level team will review annual reports from community-based CFR teams and prepare statewide report;
4. Encourage all Ohio county to implement (sic).

The target for Calendar Year 2003 was to have all steps completed. Ohio has met its goal.

1. The Ohio CFR project used findings and recommendations of CFR to reduce childhood morbidity and mortality. The fourth annual CFR report was published in the fall of 2004 and distributed to the Ohio Legislature, Local CFR Boards, Family and Children First Councils, CFR Advisory Committee and other interested parties. The report provides data from reviews of child deaths which occurred in 2002. The report includes the numbers and causes of child deaths in Ohio, and presents local CFR boards' findings, recommendations, and initiatives to prevent other child deaths. The report and other CFR findings have been distributed to other agencies and groups that can use the information to develop prevention strategies.

2. The Ohio CFR project increased the capacity of local Ohio CFR Boards to review all deaths of children under the age of eighteen. The Third Annual Training Conference for the Ohio Child Fatality Review was held November at the Marriott North in Columbus Ohio, with over 200 participants representing 70 counties. In addition to the training opportunities at the conference, technical assistance was provided throughout the year to local CFR boards regarding board process and data reporting. All 88 counties submitted annual reports to ODH by April, 2003, as required by law.

3. The Ohio CFR project explored CFR legislative needs in Ohio. The CFR Policy group met with the Bureau legal counsel and the Division Chief to discuss weaknesses in the current CFR law and rules, and the impact of these weaknesses on the success of the program.

4. The Ohio CFR project promoted partnerships at the local and state levels to enhance the exchange of information about child fatality reviews and their findings. The CFR Advisory Committee members reflect members of local CFR boards, state agencies and other organizations, and met in July, 2003. CFR information and findings have been shared with Children's Trust Fund, SID Network of Ohio, and other ODH staff in CFHS funded programs. CFR staff have promoted the exchange of information by participation on MCH Block Grant Strategy groups and Emergency Medical Services for Children group. A Motor Vehicle Death subgroup and a SIDS/Sleep-related Death subgroup have been formed with members from ODH, Public Safety, law enforcement, child care advocates, coroners groups and other interested parties to share information and develop prevention strategies.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Ohio CFR project used findings and recommendations of CFR to reduce childhood morbidity and mortality. The fourth annual CFR report was published in the fall of 2004 and distributed to the Ohio Legislature, Local CFR Boards, Family and Children F				X
2. The Ohio CFR project increased the capacity of local Ohio CFR Boards to review all deaths of children under the age of eighteen. The Third Annual Training Conference for the Ohio Child Fatality Review was held November 2003 in Columbus.				X
3. The Ohio CFR project explored CFR legislative needs in Ohio. The CFR Policy group met with the Bureau legal counsel and the Division Chief to discuss weaknesses in the current CFR law and rules, and the impact of these weaknesses on the success of C				X
4. The Ohio CFR project promoted partnerships at the local and state levels to enhance the exchange of information about child fatality reviews and their findings. The CFR Advisory Committee members reflect members of local CFR boards, state agencies an				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A. Ensure the quality of CFR data at the state and local levels.

B. Increase the capacity of local Ohio CFR boards to review all child deaths.

C. Encourage ODH, other state agencies and local CFR boards to use findings and recommendations to promote policy, legislative and program changes to reduce the incidence of childhood morbidity and mortality.

c. Plan for the Coming Year

All objectives for this performance measure have been completed; the measure will be retired.

State Performance Measure 13: *The ratio of black perinatal mortality rate to the white perinatal mortality rate*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		1.9:1	1.9:1	1.8:1	1.7:1
Annual Indicator	2.1	2.2	2.5	2.1	
Numerator	17	20	20	15	
Denominator	8	9	8	7	
Is the Data Provisional or Final?				Provisional	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	1.6:1	1.6	1.6	1.6	1.6

Notes - 2002

Data for 2002 is noth available. Data for 2002 will be available in 2004.

Notes - 2003

2003 birth data is preliminary.

Notes - 2004

2004 data is not available.

a. Last Year's Accomplishments

The target for calender year 2003 was 1:8:1. The actual ratio of black perinatal mortality rate to the white perinatal mortality rate was 2.1. Based on provisional Vital Statistics data, Ohio did not meet its target.

A. The six perinatal regions and the State Data Use Consortium teams have implemented a Perinatal Periods of Risk analytic tool to address the data relative to perinatal mortality disparities and convene focus groups bi-annually for discussion to enhanse information about birth outcomes and methods to target resources. Data analysis has been conducted from 1997 through 2001. Implemented Phase II of the Perinatal Periods of Risk targeting both African American and teen births. Presented results to Birth Outcomes workgroup and to CFHS, OIMRI and RPC project directors in order to target interventions and priority populations.

B. Twelve Ohio Infant Mortality Reductions Initiatives (OIMRI) programs were funded in Ohio. Five site visits were made that included visits to the homes of clients.

C. The ODH collaborated with the Ohio Commission on Minority Health. Discussions on how to adopt policies that define and mandate culturally competent practices will be addressed in the

next fiscal year.

D. The two additional OIMRI programs completed their first full year of service. Two four-day workshops entitled, Partners for a Healthy Baby, Home Visiting Expectant Families & Families with Infants, were held for perinatal providers. A total of 104 attendees included community health workers, CFHS prenatal staff and Help me Grow service providers. In a concerted effort to foster the collaboration of the OIMRI Community Care Coordination Programs with local Help Me Grow (HMG) Programs, BEIS and BCFHS hosted a joint meeting for OIMRI and HMG service providers. There was representation from about 90 percent of the programs throughout the state. BCFHS provided technical assistance to all 12 funded OIMRI programs. On-site monitoring visits were made to five projects. Staff from BCFHS served on the Community Care Coordination Collaborative Executive Council and attended scheduled meetings.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The six perinatal regions and the State Data Use Consortium teams have implemented a Perinatal Periods of Risk analytic tool to address the data relative to perinatal mortality disparities and convene focus groups bi-annually for discussion and shari				X
2. Site visits were made to five of twelve Ohio Infant Mortality Reduction Initiatives (OIMRI) programs were funded in Ohio.				X
3. The ODH collaborated with the Ohio Commission on Minority Health. Discussions on how to adopt policies that define and mandate culturally competent prctices will be addressed in the next fiscal year.				X
4. Two four-day workshops, entitled Partners for a Healthy Baby and Home Visiting Expectant Families & Families with Infants, were held for perinatal providers.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A. Implement the phase three of the Perinatal Periods of Risk (PPOR) methodology to enhance information from birth outcomes data in order to inform stakeholders and to target Division of Family and Community Health Services (DFCHS) resources.

B. Communicate findings of the analysis conducted on the cultural competency of Child and Family Health Services (CFHS) projects.

C. Provide technical assistance and training regarding culturally competent practices to Division of Family and Community Health Services (DFCHS) funded projects.

D. Fund, monitor, and provide technical assistance to program that provide community care coordination services.

E. Fund, monitor, and provide technical assistance to the Ohio SIDS program, especially in regards to reducing the African American Sudden Infant Death (SID) rate in Ohio.

F. Analyze and report best practices for five birth outcomes performance measures (National 15, 17, 18 and State 11 and 7).

c. Plan for the Coming Year

This measure is being retired.

State Performance Measure 14: *The reported cases of physical assault by current or former intimate partners (Domestic Violence)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	6.5	4	3.5	1.7	1.7
Annual Indicator	1.8	3.7	1.8	2.5	
Numerator	17004	35539	17208	23372	
Denominator	9446316	9501122	9537961	9537961	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	1.7	1.7	1.7	1.7	

Notes - 2002

Data source: Ohio Incident-Based Reporting System (OIBRS). Numerator included data from 171 OIBRS participating agencies collected from 1-1-2000 - 12-31-2001. The noticeably higher domestic violence figures and the significant difference from last year are due to a change in sources of data.

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Notes - 2003

Data source: Data based on Ohio Bureau of Criminal Identification and Investigation Domestic Incidence Datasets, Office of Criminal Justice Services. Note that starting in 2002, BCI only reports incidents of DV where violence resulted, regardless of whether the victim was injured in the incident.

2003: Data only includes victim type, wife, husband, former spouse, Live-in-Partner, and includes victim with injury and victim without injury.

Notes - 2004

Data for 2004 is not available.

a. Last Year's Accomplishments

The target for Calendar Year 2003 was 1.7 percent. The actual percent of reported cases of physical assault by current or former intimate partners (domestic violence) was 2.5. Ohio did not meet its target.

A. DFCHS staff were trained on Battered Women's Syndrome. The training, presented by DOP's women's health program, provided information on how to recognize domestic abuse; battered person syndromes; and resources available to call on within ODH and the community when it is suspected at work.

B. ODH assessed the capacity of providers to recognize domestic violence and how to provide referrals. Training was made available from the Ohio Domestic Violence Network (ODVN) in four regions of Ohio.

C. ODH provided training through the ODVN, to providers to educate clients to identify domestic violence and how to address date violence in relationships. Providers were monitored by chart audits to assess referrals and follow-up. Family Planning and Women's Health Services providers were directed that referrals were not complete until clients had completed the appointment.

D. ODH provided domestic violence training to providers. The ODVN provided training in four regions. ODH staff attended training but there has been sufficient turnover in staff that new members will attend training in 2005.

E. ODH conducted a needs assessment that included training from the ODVN and facilitated by DOP's Women's Health Program. The needs assessment results indicated additional training opportunities were both needed and desired by public health providers.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Division of Family and Community Health Services staff were trained on Battered Women's Syndrome.				X
2. ODH assessed the capacity of providers to recognize domestic violence and how to provide referrals. Training was made available from the Ohio Domestic Violence Network in four regions of Ohio.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A. Train all DFCHS programs to identify Battered Women's Syndrome.

B. Assess the capacity of health care providers in DFCHS-funded agencies to assess domestic violence and to provide appropriate referrals for women.

C. Educate providers in DFCHS-funded agencies and school nurses with the legal system's application of penalties and adjudication regarding domestic violence.

D. Provide training for providers of the 15-44 year old target group about identifying domestic violence and date violence.

c. Plan for the Coming Year

This measure is being discontinued.

State Performance Measure 15: *Percentage of children in kindergarten and 1st grade failing a vision screen*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		6.0	6.0	5.9	5.9
Annual Indicator		7.0	7.0	7.3	
Numerator		19776	19776	19398	
Denominator		281784	281784	265924	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5.8	5.8	5.8		

Notes - 2002

Data are from a survey to a statewide sample of schools administered every other year. Current data are from the 1999-2000 survey.

Data for 2002 is the same as 2001 because the survey that generates the data is done every two years.

Notes - 2003

Data are from a survey to a statewide sample of schools administered every other year. Current data are from the 2000 - 2001 survey.

The sampling methodology covered the entire state and involved the selection of every 6th school building. There are 4,711 schools with 790 of them sampled and 92% responding.

Notes - 2004

Data is not available at this time.

a. Last Year's Accomplishments

The target for Calendar Year 2003 was 5.9 percent. The actual percent of Ohio children in Kindergarten and first grade failing a vision screen was 7.3 in 2003. Ohio did not meet its target.

A. "The Specialty Medical Clinic program worked to improve and increase training on vision assessment and referral for primary physicians. Preschool vision screening reference materials were distributed to physicians. Vision assessment information was presented at four regional conferences. A vision screening videotape was produced with the emphasis on school-age children and distributed to participants of ODH vision screening training. Nursing programs were offered the opportunity for workshops and vision trainings.

B. "The Specialty Medical Clinic program increased utilization of existing vision resources with specific emphasis on reducing racial disparity in the utilization of vision care services. A request was submitted to Medicaid to determine utilization of vision care services by children on Medicaid. Meetings continue with the Ohio Primary Providers Vision Screening Coalition to discuss barriers to vision care and ways of increasing utilization of vision resources.

C. "Staff in the Specialty Medical Clinic program worked to increase compliance with preschool vision screening standards of ODH. The participation in quarterly meetings of the Ohio Primary Providers of Vision Screening Coalition provided the opportunity to discuss compliance of preschool vision screening rates. Preschool vision screening procedures and recommendations have been presented during the regional and in-house vision screening trainings.

D. The ODH worked to develop a statewide unified preschool vision screening data collection system. Participated in Bureau of Oral Health statewide preschool dental survey to determine the number of preschool children that have received a vison examination or vision screening. A survey was completed and results are being analyzed. Preliminary data indicates that two thirds of children that participated in the survey had their eyes screened or examined prior to entering Kindergarten.

E. "The ODH increased public (parent) awareness of the importance and need for early professional eye care for children. A meeting was initiated with the American Academy of Pediatrics/Ohio and a preschool vision screening poster was developed for use in the office of eyecare professionals. The poster was designed to promote the importance of early childhood vision exams by an eyecare professionals. A PH1 segment was produced to stress the importance of early vision care.

F. The Specialty Medical Clinic program began the preliminary process to collaborate with ODJFS and ODE to include a vision screening prompt on the annual medical evaluation form for child day care centers.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Specialty Medical Clinic program worked to improve and increase training on vision assessment and referral for primary physicians. Preschool vision screening reference materials were distributed to physicians; assessment information was presented				X
2. The Specialty Medical Clinic program increased utilization of existing				

vision resources with specific emphasis on reducing racial disparity in the utilization of vision care services. A request was submitted to Medicaid to determine utilization of vi				X
3. Staff in the Specialty Medical Clinic program worked to increase compliance with preschool vision screening standards of ODH.				X
4. The ODH worked to develop a statewide unified preschool vision screening data collection system.				X
5. The ODH increased public (parent) awareness of the importance and need for early professional eye care for children.			X	
6. The Specialty Medical Clinic program began the preliminary process to collaborate with ODJFS and ODE to include a vision screening prompt on the annual medical evaluation for for child day care centers.				X
7.				
8.				
9.				
10.				

b. Current Activities

A. Improve and increase training on vision assessment and referral for primary care providers.

B. Increase utilization of existing vision resources with specific emphasis on reducing racial disparity in the utilization of vision care services.

C. Increase compliance with preschool vision screening standards of the Ohio Department of Health.

D. Develop a statewide unified preschool vision screening data collection system.

E. Increase public (parent) awareness of the importance and need for early professional eye care for children.

F. Collaborate with ODHS and ODE to include a vision screening prompt on the annual medical evaluation form for child day care centers.

c. Plan for the Coming Year

This measure is being discontinued and will be replaced with: Increase the proportion of children who receive age and risk appropriate screenings for lead, vision, hearing and oral health.

State Performance Measure 16: *Assess the capacity to integrate genomics into public health programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual					

Performance Objective	1	1	2	3	3
Annual Indicator			2.0	3.0	3.0
Numerator			2	3	3
Denominator	3	3	3	3	3
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	3	3	3		

Notes - 2002

This is a process measure that includes the following steps:

1. The director of health will convene a task force on genetics to review new genetics information.

2. The task force will develop a work plan of activities that will result in a document of recommendations to the director of health.

3. ODH will develop a state genetics plan for 2002/2007, incorporating recommendations from the task force.

Notes - 2003

1. The director of health will convene a task force on genetics to review new genetics information.

2. The task force will develop a work plan of activities that will result in a document of recommendations to the director of health.

ODH will develop a state of genetics plan for 2002/2007, incorporating recommendations from the task force.

a. Last Year's Accomplishments

Formerly: Development of the role of the new Genetics in public health programs.

Revised to: Assess the capacity to integrate genomics* into public health programs.

This is a process measure that includes the following steps:
1. The director of health will convene a task force on genetics to review new genetics information;
2. The task force will develop a work plan of activities that will result in a document of recommendations to the director of health;
3. ODH will develop a state genetics plan for 2002/2007, incorporating recommendations from the task force.

The target for Calendar Year 2003 was to complete Step 3. The target has been achieved.

A.Re-focus priorities and adjust activities of ODH-funded Regional Comprehensive Genetic Centers (RCGCs) based on recommendations from the Director's Genetics Task Force.
*Genetics RFP for 07/01/04 start date revised to require Grand Rounds presentation for providers on expanded newborn screening in Ohio.

*Mid-year data report due in Feb. 2005 for monitoring status of education activities.

B.Collaborate with program staff in the Division of Prevention to identify activities and implement broad prevention/educational recommendations of the Genetics Task Force statewide.
*Cancer-Genetics Workgroup convened.
*Low literacy patient information developed and disseminated to all genetic/cancer centers.
*RCGC information provided in ACS "Cancer Solutions" newsletters.
*RCGC information provided to all local health department cancer contacts.

C.Revise genetics state plan to incorporate new genomics and integrate genetics and prevention activities.
*Genetics state plan currently on hold so that it may be integrated into Ohio's developing birth defects information system initiative which also includes prevention activities.
*ODH-funded genetic centers continue to provide folic acid information to clients and activities continue to integrate genetics into other public health programs.

D.Monitor activities of RCGC through site visits, programmatic reports and data collection.
*2 RCGC Center Directors meetings held.
*Data collected from all but one center, which is experiencing computer system problems. 2003 Annual Data Report due in early 2005.

E.Integrate genetics component into Ohio's Universal Newborn Hearing Screening Program.
*2 Meetings held with Bureau of Early Intervention Services administrators.
*BCMH and Genetics are represented on Ohio's Newborn Hearing Screening Advisory Council.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Genetics program convened a Cancer-Genetics Workgroup. Developed and disseminated low literacy patient information to all genetic/cancer centers. Regional Comprehensive Genetics information provided in American Cancer Society "Cancer Solutions" newsl			X	
2. ODH-funded genetic centers continued to provide folic acid information to clients and activities continue to integrate genetics into other public health programs.			X	
3. Genetics program monitored activities of Regional Comprehensive Genetics Centers through site visits, programmatic reports and data collection.				X
4. Activities undertaken to integrate genetics component into Ohio's Universal Newborn Hearing Screening Program.				X
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities

Formerly: Development of the role of the new Genetics in public health programs.

Revise to: Assess the capacity to integrate genomics* into public health programs.

Genomics is defined by the Association of State and Territorial Health Officials (ASTHO), as the study of the functions and interactions of all the genes in the genome*. This encompasses gene interactions with environmental factors, and all of the scientific discoveries and the health and social implications connected with this process.

Genome is defined as all the DNA contained in an organism or cell, which includes both the chromosomes within the nucleus and the DNA in the mitochondria.

Activities:

A. Identify public health programs for possible integration with genetics/genomics.

B. Monitor integration activities of the Regional Comprehensive Genetics Centers (RCGC) with public health programs including metabolic services, newborn screening, specialty medical teams (such as BCMH Myelodysplasia and Craniofacial teams, etc.), birth defects surveillance and local health departments.

c. Plan for the Coming Year

This measure is being discontinued.

E. OTHER PROGRAM ACTIVITIES

E. OTHER PROGRAM ACTIVITIES

Title V Help Line
Since February 1995, DFCHS has operated the Help Me Grow (HMG) help line, a statewide toll-free 800 number, which provides health and social service referrals and information to callers and is also the toll-free number for Title V programs. Information on programs from the following state agencies is currently available: Education; Health; Job and Family Services; Mental Health; and Mental Retardation and Developmental Disabilities, as well as local sites for clinical services. The goal of the helpline is to allow for a single, clearly identifiable point of contact to obtain information on state programs and agencies serving families and children. During SFY04, the HMG help line received 43,277 calls of which 15,036 were transferred or referred to BCMH. The HMG help line is available to callers twenty-four hours a day, seven days a week. Weekly and monthly reports on calls received and referrals made are reviewed by state staff. Periodic evaluations of the help line are conducted to determine client satisfaction and outcome.

The Help Me Grow help line is collaborating with the Incident Command System to handle incident related calls. The helpline is prepared to take these calls twenty-four hours a day, seven days a week and has developed a plan to quickly prepare and respond to calls.

The State Trauma Committee
The DFCHS provides a liaison from the ODH to the state Trauma Committee. The state Trauma Committee is a legislated committee of the state EMS Board, which is staffed by the Ohio Department

of Public Safety. The liaison represents the needs of those served by the DFCHS and ODH. The statewide Trauma System authorized through state legislation in 2000 has completed the basic tasks for organizing the system and is now in a maturation phase. The DFCHS liaison has facilitated discussions between Trauma System stakeholders and programs within ODH. These have included the Bioterrorism Program, the Injury Prevention Program, the Bureau for Children with Medical Handicaps, the School Health Program and provisionally designated trauma centers.

Ohio Compassionate Care Task Force
As Chair of the Ohio Compassionate Care Task Force, the DFCHS Medical Advisor has become involved with the Ohio Partners for Cancer Control and the Ohio Pain Initiative, organizations which will participate in implementing the recommendations of the Task Force. These recommendations address individuals with chronic pain and those in need of palliative care connected with terminal illness. The Compassionate Care Task Force is legislatively mandated. This group is to make recommendations to the Governor and the Ohio General Assembly on ways to improve the practice of pain management for those with chronic pain and those who are terminally ill.

Dental OPTIONS
BOHS collaborated with the Ohio Dental Association to administer OPTIONS, the statewide dental program for Ohioans with no dental insurance or resources to pay for care. Four agencies were funded to administer OPTIONS regionally. 5,403 people were helped; $1,153,068 in dental care was discounted/donated; 778 dentists and 91 dental labs are enrolled in OPTIONS;

School Injury Report Form
An ODH standardized school injury report form has been created and piloted in two rural school districts over the last two years. This second year of the pilot included computerizing the reports and electronically reporting on a quarterly basis to the ODH. The standardized report form has been widely accepted due to its objective nature and ease in completing. Based on the pilot the guidelines for use were expanded to include minor injuries that are recorded more often than emergency visits or loss of school days due to injuries. Each of the two pilot school districts formed a school safety committee to review the injury data on a quarterly basis and will continue that process as a forum for recommendations on school safety issues. Additionally schools in the rural part of Ohio need assistance in computerization of records which do not exist currently, complicating the electronic injury record keeping. The school injury report form was shared with all school nurses in Ohio. The injury report form has become a standard ODH form which is accessible on the web and is being used and marketed to schools.

Newborn Screening Followup
Ohio's newborn screening legislation does not require physicians to report the initiation of treatment information back to the ODH, therefore, the information is not well documented or collected by the ODH newborn screening lab. Within ODH, activities related to short term newborn screening follow-up (laboratory testing to diagnosis confirmation) and long term newborn screening follow-up (from confirmatory diagnosis to treatment initiation) for phenylketonuria (PKU) and hemoglobinopathies reside in different divisions. The ODH DFCHS recognizes and approves Metabolic Service Teams throughout the state that provide services to individuals with PKU, and financially supports Regional Sickle Cell Services Projects that provide services to individuals with sickle cell disease, sickle cell trait and other hemoglobinopathies. Through these relationships, ODH is able to assure that 100% of children identified with PKU and sickle cell disease through Ohio's newborn screening program receive treatment. We are actively collaborating on improving our department's reporting capabilities on this issue.

F. TECHNICAL ASSISTANCE

Technical Assistance Requests (not listed in order of preference or importance):

1) The Division of Family and Community Health Services is requesting technical assistance to support a visit to Ohio to provide assistance on data integration in relation to activities needed to

develop new State Performance Measure 10 (MCH data Integration). The planned strategies for the first year call for assessing the cost and benefits of an integrated information system and prioritizing the data integration needs. Assistance is requested from Alan Hinman, Public Health Informatics Institute and a representative from another state.

2. Ohio is requesting technical assistance on state funding sources for Title V CSHCN Programs and assistance in researching how other state Title V CSHCN programs are organized and funded. Ohio has a BCMH (CSHCN Title V) Legislative Taskforce that is exploring ways to fund CSHCN programs.

V. BUDGET NARRATIVE

A. EXPENDITURES

A. Expenditures

Form 3 -- FFY04

Ohio continues to spend more than its federal allocation. Typically, Ohio plans to use its un-obligated balance to support MCH activities during the first quarter of the new federal fiscal year while it waits on the arrival of the new notice of award.

The FFY04 Federal-State Title V Block Grant Partnership expenditures were $60,589,472. This is $1,365,617 less than the FFY03 expenditures of $61,955,089.

Overall FFY04 expenditures (including other federal funds) related to MCH activities were $309,699,673. This is $14,841,379 above the FFY03 expenditures of $294,858,294.

Form 4 -- FFY04

FFY04 expenditures for pregnant women of $6,483,236, infants of $2,829,548, and children (1-22) of $18,158,554 are all below the FFY03 expenditure levels for each respective category. However, FFY 04 expenditures for children with special healthcare needs of $32,542,834 are $2,754,815 above the FFY03 amount of $29,788,019. The increased CSHCN cost can be attributable to rising medical costs and an expanding population. Ohio took action FFY 04 to contain these raising costs.

The FFY04 administration expenditures were $575,300.This is 338,065 less that the expenditure for FFY04 which were 914,065. The reduction in administration cost is due to the reduction of staff. Ohio is well within the 10 percent administration requirement.

Form 5 -- FFY04

FFY04 expenditures for Direct Health Care Service of $35,309,745, Enabling Services of $10,058,618, Population Based Services of $5,456,689, and Infrastructure Building Services of $9,764,420 are 58.3 percent, 16.6 percent, 9.0 percent, and 16.1 percent of total Federal-State Title V Block Grant Partnership expenditures, respectively.

Ohio is aware that its pyramid structure is heavy in the area of direct services; however, Ohio is making a concerted effort to model the MCH service pyramid. For example, Ohio's Community and Family Health Services bureau is in the process of making significant changes in how it funds the Community and Family Health services sub-grant program (i.e., become more in line with the MCH pyramid). Ohio will continue to strive to make changes to its methods of service delivery and become more focused on population, enabling, and infrastructure services.

B. BUDGET

B. BUDGET

3.3 Annual Budget and Budget Justification
Summary Budget FY2006
Component A: Services for Pregnant Women, Mothers and Infants up to age one year
Component B: Preventive and Primary Care Services for Children and Adolescents
Component C: Family-Centered, Community-Based, Coordinated Care and the Development of Community-Based Systems of Care for Children with Special Health Care needs and their families.

Component A: $9,711,722
Component B: $5,486,508

Component C: $7,326,383
Subtotal: $22,524,613

Administrative Costs: $439,037

GRANT TOTAL: $22,963,650 This figure represents about 99 percent of Ohio's FFY05 NOA.

* Administrative costs are applied proportionally to Components A, B and C.

Budget Justification

Services for Pregnant Women, Mothers and Infants to Age One
In its FFY2006 request, Ohio has budgeted $74,301,284 for services for Pregnant Women, Mothers and Infants to Age One; 22.11 percent of the $336,274,809 total funds targeted for Title V related activities. For this component, MCH Block Grant funds total $5,486,508 or 23.89 percent of the $22,963,650 MCH Block Grant request. Other State and Federal funds for this component total $68,814,776 or 22.97 percent of the budgeted $313,161,159 in other Title V related funds.

Preventive and Primary Care Services for Children and Adolescents

In its FFY2006 request, Ohio has budgeted $224,018,251 for Preventive and Primary Care Services for Children and Adolescents or 68.43 percent of the $336,274,809 total of all funds designated for Title V and related activities. MCH Block Grant funds for this component total $9,711,722 which is 42.29 percent of the $22,963,650 MCH Block Grant request. Other State and Federal funds for this component total $214,306,529 or 68.43 percent of the $313,161,159 of other Title V related funds.

Children with Special Health Care Needs

In its FFY2006 request, Ohio has budgeted $37,434,707 for activities for Children with Special Health Care Needs or 11.14 percent of the $336,274,809 of total funds budgeted for Title V and related activities. For this component, MCH Block Grant funds total $7,326,383, which is 31.9 percent of the $22,963,650 MCH Block Grant request. Other State funds for CSHCN total $30,108,324 or 9.61 percent of the $313,161,159 of other Title V related funds.

Administrative Costs

$439,037 in MCH BG funds.

Maintenance of State Effort
In 1989, Ohio's MCH Block Grant award was $19,369,474 and the state provided $23,812,983 in support of the MCH activities. The fiscal year 2006 federal MCH award is expected to be $22,963,650 and the state will provide $33,391,338. State support is provided by appropriations from several state line items and one source of county funds which the Division is authorized to spend on behalf of children with special health care needs. The particular line items and their level of funding in 1989 and 2006are shown below.

Description----------1989----------2006
Sickle Cell Control----------421,347---------1,035,344
Genetic Services----------1,144,281----------0
Child & Family Health Services----------5,652,423----------4,643,523
Adolescent Pregnancy----------400,000----------0
Medically Handicapped Children--------4,682,744----------9,591,784
Cystic Fibrosis----------325,394----------0
Medically Handicapped Audit Funds----1,312,168----------3,800,000
Medically Handicapped County Funds--9,874,626--------14,320,687

Total----------$ 23,812,983-------$33,391,338

To determine the total amount of state match and funding of MCH programs, the Division of Family and Community Health Services totals several of the state appropriation line items which are dedicated to Title V related activities. The authorization levels of the line items are determined by the State Legislature as part of the biennial budget process, but actual expenditures may depend upon executive order reductions, reimbursement limits and revenue limitations. The above Maintenance of Effort chart lists the 2006 state appropriations as outlined in the Ohio Department of Health (Division of Family and Community Health Services) spending plan. The cystic fibrosis and genetics appropriation line items are no longer shown as match/maintenance of effort because they are dedicated to the provision of services to adults. Services for children with cystic fibrosis or other genetic related problems are supported by other state CSHCN funds. $1,700,000 of the state Child and Family Health Services appropriation is not included as match for the Title V award because it is designated as part of a new state initiative called Women's Health (previously dedicated to family planning services). An additional $900,000 of the CFHS appropriation is set-aside for Federally Qualified Health Centers and is not included on Form 424, Line 15c as match to Title V funds. These funds are included in Line 15e because the population to be served is broader than the population served by MCH funds.

Ohio continues to experience a drop in expected revenue receipts. This has had an impact on the amount of General Revenue funds available to support MCH and other state initiatives. Ohio's maintenance of effort has increased by 9,406,979 from 23,984,359 in 2005 to 33,391,338 in 2006. The major reasons for this increase are due to: 1) increased state support for CSHCN; 2) Reinstatement of state CFHS Funds as match to the title V award.

Rate Agreement
STATE AND LOCAL DEPARTMENT/AGENCIES

EIN NO: 1-316402047-A1

DEPARTMENT/AGENCY: Ohio Department of Health Date: February 13, 2003
246 North High Street
P.O. Box 118 FILING REF: The preceding
Columbus, Ohio 43266-0118 Agreement was dated 9/24/01

The rates approved in this Agreement are for use on grants, contracts and other agreements with the Federal Government subject to the conditions in Section III.

SECTION I: INDIRECT COST RATES

Type From To Rate Locations Applicable to
Fixed 7/1/01 6/30/02 31.5% On Site Unrestricted (1)
Fixed 7/1/02 6/30/05 32.0% On Site Unrestricted (1)
Final 7/1/01 6/30/02 16.4% On Site Restricted (2)
Provisional 7/1/02 6/30/05 16.4% On Site Restricted (2)
Provisional 7/1/05
Until amended, use same rates and conditions as those cited for fiscal year ending June 30, 2005.
Restricted rate is for U.S. Department of Education Programs which require the use of a restricted rate as defined by 34 CFR Parts 75.563 & 76.563.
1) Base -- Direct salaries and wages including all fringe benefits.
2) Base -- Total direct costs excluding capital expenditures (building, individual items of equipment, alterations and renovations, sub-awards and flow-through funds).

Administrative Costs:
The administrative costs of Ohio's 2006 MCH Block Grant request are based on budget and

expenditures related to the Operational Support Section of the Bureau of Health Services Information and Operational Support. The Operational Support Section is responsible for administrative activities (e.g., grant processing, purchasing, personnel, etc.) associated with MCH and MCH related programs. In FFY2004, an administrative time study was conducted. The goal of the study was to measure the time spent by administrative staff supporting activities of the Division of Family and Community Health Services (where Title V funds are administered) for all major funding sources.

FFY2006 Carry Over Funds:
The amount of carryover funds is based on the total amount of funds available in 2005 less projected expenditures and encumbrances as recorded through February 2005. In FFY2005 a total of $26,348,386 in MCH Block Grant funds were available to the State of Ohio. According to the Department's accounting reports, which reflect activity through February 2005, projected expenditures and encumbrances to be posted against FFY2005 MCH funds will total $22,084,036. When total available funds are reduced by total project expenditures and encumbrances, the Division expects to have an unencumbered balance of $4,264,350.

The Ohio Maternal and Child Health Programs support the authority of states to use unobligated funds in the next fiscal year. This authority, set forth in section 503 (b) of Title V, has been a cornerstone to enable state MCH agencies to provide funding stability in their local partners and flexibility in the design of statewide programs. Ohio's experience has been that the projected lapsed amount is equal to approximately 1.5 months worth of its 1st quarter expenditures. Therefore, Ohio will need to receive its FFY05 NOA no later than November 15, 2004 in order to provide continuity of services to our local partners who otherwise could be forced to interrupt services.

VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

X. APPENDICES AND STATE SUPPORTING DOCUMENTS

A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.